Department for Education

Step Change: an evaluation

Research report

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Glossary of key terms

Action for Children (AfC)
Child in Need (CIN)
Child protection (CP)
Evidence based programme (EBP)
Employment, education and training (EET)
Functional Family Therapy (FFT)
Good Childhood Index (GCI)
Local Authority (LA)
Looked After Child(ren) (LAC)
Multi-systemic Therapy (MST)
Medical Research Council (MRC)
Primary caregiver (PC)
Randomised Controlled Trial (RCT)
Service Provision Checklist (SPC)
Single Referral Pathway (SRP)
Step Change Referral Panel (SCRP)
Standard Deviation (SD)
Step Change (SC)
Step Change Advisor (SCA)
Strengths and Difficulties Questionnaire (SDQ)
Treatment Foster Care Oregon (TFCO)
Young person (YP)
Youth Offending Services (YOS)
West London Alliance (WLA)

Executive summary

The Step Change project

Step Change was created as a partnership involving 3 Local Authorities (LAs) and the children's charity, Action for Children (AfC). It intended to improve outcomes for young people (aged 11 -17 years) on the edge of care or custody and their families, by introducing evidence based programmes (EBPs). The project secured DfE innovation programme funding to run the first year of the project, with the expectation that the LAs would invest in the continuation of the model as it was rolled out to other LAs. The University of York Departments of Health Sciences and Social Policy and Social Work were commissioned to undertake a 9 month evaluation of the implementation and early impact of the project. This was extended to 14 months to accommodate delays to project start-up (June 2015 – August 2016).

The project initially intended to provide 3 EBPs; however, a decision was taken early on to remove Treatment Foster Care Oregon (TFCO) due to concerns about the costs and resources required and the availability of evidence of its effectiveness in the UK. Step Change therefore comprised the following EBPs:

1. Functional Family Therapy (FFT) delivered over 3 to 5 months on a weekly basis, for families with young people aged 11-17 years old with behavioural or emotional problems
2. Multi-Systemic Therapy (MST) delivered over 3 to 5 months with 24 hour access to support, for families with young people aged 11-17 years at risk of out of home placement due to offending or severe behaviour problems

Step Change aimed to improve long term outcomes for young people by decreasing risk taking behaviours including offending, increasing engagement in education, employment and training (EET), and improving relationships between young people and their families to avoid family breakdown, and to reduce the need for care or custody.

In addition, Step Change aimed to bring about a cultural shift and improve service provision and efficiencies across the partner organisations by developing standardised best practice in delivering the EBPs; providing more efficient management of resources across the LAs by using a single delivery model for both EBPs; and reducing the number of adolescents entering care or custody and the associated costs.

Project implementation

Step Change aimed to support 170 young people within 2 years of operating. A single referral pathway (SRP) was established and panel meetings were introduced to manage

referral and allocations of young people from the LAs. New posts were to include 6 Step Change Advisors (SCAs, 2 in each LA) to work with social care staff to identify families eligible for the EBPs and a Sustainability Worker to provide follow-up support to the young people post-intervention. However, changes to the model led to a reduction in the number of SCAs and the removal of the latter post completely.

Evaluation methodology

The evaluation comprised 3 work packages: an outcome evaluation, an implementation evaluation and an economic evaluation. Methods included quantitative, qualitative and participatory approaches to ensure that the perspectives of stakeholders were reflected throughout. Data extraction from LA and project data systems, outcome measures, surveys and interviews were undertaken at baseline and at follow-up, which ranged from 5 to 7 months later. A sample of 67 families was included at baseline: 63% allocated to FFT and 37% to MST. Data were available for 57 cases at follow-up, 15 of whom were also interviewed. For the implementation evaluation, surveys (n=28) and interviews (n=16) were carried out with key staff across the partner agencies at baseline and repeated at follow-up. Limitations of the study included high levels of missing and unreliable data for some variables, and the lack of a control group. Additionally, compressed follow-up timescales, and lower than expected sample sizes, restricted the extent to which the planned outcome and economic components could be fully achieved. The findings should be interpreted with caution.

Key findings

1. Families using Step Change presented with significant needs and difficulties at referral to the project. There was evidence of multiple referrals to agencies dating back several years for many young people, with 39% having been involved with children's services for 5 years or more. Involvement with children's social care included child protection registrations and previous care episodes. Difficulties experienced by primary caregivers included domestic violence (51%) and mental health problems (39%). The majority (61%) of young people were reported to be experiencing multiple difficulties (that is, 5 or more risk factors present at referral) including aggressive, anti-social and offending behaviour. Young people in the sample were experiencing much greater levels of emotional and behavioural difficulties (as measured by the SDQ) than other young people of a similar age living in the UK.

2. It seemed likely, given the extent of the difficulties families were presenting with, that Step Change was, in most cases, being used by those close to the edge of care. There were, however, some young people entering Step Change as a result of their first referral to children's social care and some who presented with a lower level of difficulties.

Existing research acknowledges the difficulties in identifying the edge of care group when targeting preventative programmes and strategies.

3. Follow-up measures, which were not completed in sufficient numbers to provide a reliable analysis, presented a mixed picture, with some progress evident over time for some families. Perspectives gathered at interview revealed that most of the 15 families felt Step Change had been a positive intervention that had improved their quality of life. Factors that appeared to make a difference included the consistency, frequency and accessibility of the therapy, the meaningful relationship formed with therapists and their perceived impartiality. Parents also described a sense of empowerment and confidence that came from developing new parenting skills and strategies. Though, in some cases, baseline difficulties persisted to some degree, parents reported being better able to manage ongoing and emerging problems.

4. Findings from the implementation study highlighted barriers and facilitators involved in implementing, operating and sustaining Step Change. Facilitators included a willingness to work together and solve problems; an effective referral and allocation system; and the effective contributions made by SCAs. Among the main challenges were unrealistic timescales for negotiating the logistics and the intricacies of introducing two new approaches across multiple organisations. The bid itself was also considered to be overly ambitious in its longer term projections, particularly in terms of its financial sustainability. Consequently, the original model was scaled back, and, despite operating with a degree of success for almost one year, the organisations reached a decision to close the project. Influencing factors included insufficient time to test and evaluate impact; the impact of budget cuts and wider austerity measures on LA resources; limited strategic buy-in; and insufficient demand. Organisational leads suggested matched funding and greater flexibility in procurement regulations as potential facilitators of sustainability.

5. The evaluation was not designed to examine cost-effectiveness. It had intended to provide a focused analysis of service use and associated costs for the Step Change sample. As has been identified in other studies, service use by young people and their families is difficult to extract from case management systems. Though some information was available from the LAs participating in this project, the data were partial and unable to support our intended analysis. Instead, we were able to capture service use, as reported by a sub-sample of parents, using a brief checklist. These data enabled a modest and descriptive analysis of service use over the preceding 3 months and associated costs. The findings suggested that families were in contact with a range of services during their Step Change intervention, though the contact time spent with different professionals appeared to be minimal and associated costs low.

Learning and recommendations

The study sheds light on the conditions required to embed innovative and complex services for young people at the edge of care and custody. In the case of Step Change, key conditions included strategic buy-in from all partners at the outset, and a willingness to allow the project time to identify whether improved outcomes and financial savings could be achieved. Due to the complex nature of the project, and the difficulties of the young people and families it is designed to serve, this is likely to require a commitment of a period of years rather than months. In the current economic climate, such commitments are likely to be difficult to secure.

Nevertheless, if an opportunity arises to replicate Step Change elsewhere, the study identified learning that could be applied:

- scoping exercises could be undertaken to determine whether LAs share existing infrastructures that would enable efficient set-up of the project, and gauge willingness to be flexible on adapting systems to accommodate the service
- involvement of operational staff in the development of bids and implementation plans will help to smooth the process of setting-up the project and ensure that all partners have realistic expectations of progress
- designation of major areas of implementation to project leads or ‘champions’ would also be beneficial. Areas would usefully include: joining up of management systems; data sharing protocols; EBP licensing and site preparation; SRP and referral form preparation; marketing; and practitioner engagement
- given that the cohort of young people targeted by Step Change are involved with multiple agencies and Children’s Services departments, there is potential for the project (if effective) to produce savings across the sector. There may be potential for the setting-up of joint commissioning arrangements between health and social care to maximise the chances of sustainable implementation

1. Overview of the Step Change Project

The Step Change partnership (Hounslow, Barnet and Harrow LAs, and AfC) was created to provide a 5 year programme of support to improve outcomes for young people aged 11-17 years, considered to be on the edge of care or custody. The innovative partnership was brought together to enable the provision of evidence-based programmes (EBPs) that each LA would struggle to support independently, financially and in terms of level of demand. The EBPs were Functional Family Therapy (FFT) and Multi-systemic Therapy (MST).

What was the project intending to achieve?

The project's theory of change set out the following desired outcomes for young people and their families:

- improved levels of positive and consistent contact between young people and their parents or carers
- decreased risk-taking behaviour such as substance misuse
- improvements in young people's self-confidence and ability to deal with the challenges in their lives
- improvements in young people's educational attainment levels
- improved engagement with employment, education and training (EET)

Ultimately, Step Change aimed to reduce the likelihood, and thus the numbers, of young people entering care or custody, or reducing their length of stay where appropriate.

For the participating organisations, Step Change aimed to:

- establish a single referral pathway (SRP) across the 3 LAs to assess eligibility and allocate to the most appropriate EBP given the young person's needs
- enable LAs to pool resources in order to invest in the range of interventions
- develop standardised and best practice across the LAs

See Figure 1 in Appendix A1 for the complete theory of change.

How was it intending to achieve these outcomes?

The Step Change model envisaged the following steps:

- potentially eligible families would be identified by SCAs working in close partnership with social care staff in each LA, and referred on, via the SRP, to the Step Change Resource Panel (SCRP)

- the SCRP, meeting weekly in principle, would assess the eligibility of referred families in relation to the criteria and goals of each EBP available in the suite offered by Step Change
- eligible families would then be allocated to the most appropriate EBP, subject to therapist availability for each LA
- following successful completion of the EBP, a Sustainability Worker would provide follow-up support to the young person and the family

See Appendix A2 for the further detail on the key components of Step Change.

Eligibility for the Step Change Project

Eligibility for inclusion in Step Change was based on the criteria for the 2 EBPs, which focused essentially on young people's behavioural difficulties and a breakdown in family relationships. Essentially, MST's criteria which focussed on the young person's behaviour were more detailed than FFT, but it was also the case, unlike FFT, that MST prioritised its work on the caregivers and did not depend on the young person engaging with the programme. See Appendix A3 for further detail on the specific EBP eligibility criteria.

Relevant existing research relating to this innovation

The term "edge of care" is generally used to refer to young people at risk of entering care, though the extent to which they are at risk varies (for example, are they at immediate risk of entry or displaying risk that could lead to future entry to care). Edge of care support encompasses preventative strategies including the use of family based support for adolescents at risk of family breakdown and entry to care. There is an existing and growing body of research evidence on preventative strategies for adolescents on the edge of care (Biehal, 2005; Dixon et al., 2015; Sinclair and Burton, 1998; Statham and Holterman, 2004). The recent increased policy focus on preventative edge of care approaches has arisen in response to 4 main concerns: the high numbers of adolescents entering care; the tendency for adolescent care episodes to be short term and crisis driven; the relatively poor outcomes for care-experienced young adults in comparison to their non-care peers, and, in addition to the emotional and social costs of care, the increasing financial costs of care which are placing greater pressure on LAs to seek out more cost efficient ways of working with families.

To address these concerns and costs, a range of intensive interventions for young people in, and on the edge of, care or custody have been piloted in recent years. These approaches, developed in the US, include TFCO, MST, and FFT (see Brodie, 2012). Existing research on MST and FFT carried out in the US showed positive results in reducing youth offending and antisocial behaviour (see for example, Aos et al., 2011;

NICE, 2013) and both programmes are endorsed by a number of clearing houses such as Blueprints and Investing in Children. So far there is limited research evidence of the effectiveness of MST and FFT in the UK. Separate RCT evaluations of both MST (Fonagy et al., 2013) and FFT (Thurston et al., 2015) are currently underway in the UK.

Changes to the project's intended outcomes or activities

One of the innovative elements of Step Change was the concept of an interlinked suite of EBPs spanning a full spectrum of care needs from Functional Family Therapy through to the much more intensive Treatment Foster Care Oregon. The suite was intended to provide a menu of care far larger than currently available, enabling authorities to choose the support levels most appropriate to individual needs. The loss of TFCO meant that the project was unable to offer a service to LAC where the intention was longer-term foster care support, rather than a return home. As a result, the project was no longer able to meet objectives in the theory of change (see Figure 1, in Appendix A1) in relation to improved foster carer retention and reductions in use of residential placements and placement breakdown.

In addition to removing TFCO from the suite of EBPs, the following modifications were also made to the project, again largely driven by the need to reduce its operating costs and thus improve its viability in the longer term:

- the number of SCA posts was reduced from 6 (2 in each LA) to just 2 posts (1.5 FTE in total) spanning the 3 authorities
- the plan to employ Sustainability Workers to support the young people post-intervention was dropped. This role was also seen to conflict potentially with the requirements of the EBPs for a clean break at the end of the intervention

The context within which this innovation has taken place

For the year 2014-2015, the numbers of children in need (CIN) were similar across the 3 LAs, representing between 5% and 7% of the 0-17 age-range populations. The looked after children (LAC) populations were also generally comparable (see Table 1), representing between 0.7% and 1.3% of the 0-17 age-range populations in each LA. In Barnet, 220 10-18 year olds were LAC (73% of all LAC). In Harrow, there were 165 (67% of all LAC), and in Hounslow the figure was 203 (78% of all LAC).

Table 1: Context in the 3 Local Authorities

LA	Total population	10 – 17 year olds	CIN Aged 0 -17	LAC Total (Number aged 10-18)	Custody Aged 10 -17
Hounslow	253,957	22,479	1,681	295 (230)	9
Barnet	367,265	34,923	1,803	300 (220)	18
Harrow	243,400	23,456	1,594	165 (110)	7

Source: DfE, 2015 and 2016

National statistics showed that the LAs had relatively modest numbers of LAC: LAC populations for outer London LAs ranged from 95 to 805 in 2015. However, rising numbers of adolescents coming into care across the boroughs, and increasing evidence of poor outcomes, were key drivers for the joint commissioning of edge of care services.

2. Overview of the evaluation

The evaluation was commissioned as a 9 month programme of research, later extended by a further 5 months to enable follow-up data collection. It was designed to generate findings on short-term outcomes for children and families experiencing Step Change as well as in-depth insights into the process of implementing the project.

What were the evaluation questions?

1. Does the approach make a positive difference to young people and families?
2. Which young people and families are more likely to benefit from the approach?
3. Is the project being implemented as intended at an organisational, cultural and programme level?
4. What are the barriers, facilitators and key challenges in the implementation of the approach, and do these vary across the 3 LAs?
5. What are the benefits and drawbacks of sub-regional, LA collaboration?
6. Has Step Change provided a viable model of alternative provision for adolescents on the edge of care?

The evaluation utilised mixed methods and incorporated a participatory approach to promote the inclusion of young people's views in the research design and implementation. The methodology was informed by the Medical Research Council (MRC) guidelines on the evaluation of complex interventions (MRC, 2011) and comprised 3 complementary work packages: outcome evaluation (questions 1, 2), implementation evaluation (questions 3, 4, 5) and economic evaluation (question 6). See Appendix B1 for information on the Young People's Reference Group that supported the design and implementation of this study.

Outcome evaluation methodology

The outcome evaluation aimed to explore short-term change, as well as the characteristics and presenting difficulties of the families using the service. Baseline data were available for 67 families who started Step Change. As the duration of an average EBP intervention was understood to be approximately 5 months, the follow-up time point was set at the intervention exit date or 5 months post-baseline if the family completed earlier, or disengaged. The basic follow-up sample was 57, the reduction due to some families disengaging, or whose cases had not been open long enough.

Data were collected from 5 sources across the baseline and follow-up time points: Step Change referral form records, LA case management systems, 2 standardised measures

(the Strengths and Difficulties Questionnaire (SDQ) and SCORE-15), the Good Childhood Index (GCI), which is a measure of young people's wellbeing, and qualitative interviews carried out with a sub-sample of families that had exited the intervention (see Appendix B2 for further details of the outcome measures and procedures for the follow-up interviews).

There were varying levels of missing data at follow-up across the data sources (see Table 6 in Appendix C for a breakdown of data sources and sample sizes). A number of challenges arose around the projected data collection methods, as well as the timings, which compromised the amount and quality of data collected, as well as the eventual sample numbers:

1. The evaluation team expected to have a significant influence on the design of the referral form which was to be a primary source of baseline data on young people's characteristics and family circumstances. However, it emerged that the EBPs also had strong views on their requirements for this form, and both sets of requirements could not be fully met without the form being longer than was deemed acceptable. Some of the data the evaluation team planned to collect through this route, such as education status and engagement, and the inclusion of a request for the family's permission to contact them at the end of the treatment, were lost as a result of these negotiations.

2. It had also been established that the EBPs collected their own data on key outcomes, such as education status and engagement, and it was intended – both to avoid unnecessary duplication and to reduce the burden on the participants – that the evaluation team would have access to the data collected by the EBPs. In the event, this proved unfeasible and the evaluation team were unable to benefit from any EBP data.

3. Attempts were made to collect the data lost as a result of the above 2 points from the LA case management systems instead. However, this collection route was also fraught with difficulties (see point 5 below) and (understandably) was not set up to tie the information available to the required, specific timepoints.

4. It was intended that, having obtained permission to contact the families at the referral point, the evaluation team would then be responsible for communicating with the family at the intervention exit point, in order to set up face to face interviews and arrange for the outcome measures to be completed. In the event, the EBP therapists took responsibility and, moreover, the evaluation team was also dependent on a third party (a very busy project team) to monitor and chase up compliance. The resulting small numbers of families completing follow-up interviews and outcome measures reflect the vulnerabilities inherent in this arrangement. The suite of measures originally planned by the evaluation team was also reduced in response to concerns about the burden of administration on therapists and families.

5. Whilst the LA data teams were willing to assist, their case management systems were all quite different, and variously capable of meeting the evaluation team's data extraction needs. For example, LA1 was unable to access its education data, having outsourced its management to a private company, and LA2 was the only LA to have a fully integrated, inter-departmental monitoring system. An Excel template was developed, in consultation with the LA data teams, by means of which the data could be provided to the evaluation team in a uniform format, but it was time consuming for the data teams to complete and, where the difficulties were more intractable, the data returned were less complete.

Implementation evaluation methodology

The implementation evaluation aimed to explore the process of setting up and implementing the project as well as the key facilitators and barriers to its longer-term sustainability. Electronic surveys and telephone interviews were conducted with key stakeholders at two time points (see Appendix B3 for further detail on procedures for the surveys and interviews). A non-participant observation of one SCRP meeting was also carried out. A breakdown of data sources and sample sizes for each is available in Table 7, Appendix C.

Due to time limitations, a workshop on evidence was carried out in place of the originally planned focus groups. This was designed to generate information that would help progress future discussion and decision-making around sustainability.

Economic evaluation methodology

In the absence of a control group and due to the short time-frame, it was not possible to conduct a cost-effectiveness study. Instead, the economic evaluation aimed to provide an analysis of resource use and costs where data were available. Data came from 2 sources: LA case management systems and the Service Provision Checklist (SPC; Holmes and McDermid, 2012) completed by the families who were interviewed. See Appendix B4 for further information on these data sources.

There were significant challenges in extracting information in the format required for the economic evaluation of young people's involvement with additional services. Due to the resulting levels of missing data, findings are presented from the SPC only (see Table 8, Appendix C, for sample sizes).

A retrospective case file analysis of a comparable sample of families was originally planned in each LA to support the outcome and economic evaluation by providing a local point of comparison and to document services as usual in the absence of Step Change. Due to differences in data sharing policies, this was only possible in one LA and the data are not presented in this report: the sample size is small at only 10 cases.

3. Key findings

The outcome evaluation

Referrals to Step Change

Despite initial delays to service start-up, 130 families were referred to Step Change between 1st September 2015 and 1st June 2016. There was little variation in referral and take-up rates across the LAs (see Table 9, Appendix C), although the conversion rate from referral to take-up was smaller in LA2 than in LAs1 or 3 (44% compared to 55% and 54%). Data for two-thirds of the referrals (84, 65%) showed that 81% (69) were referred by social workers, whilst 12% (10) came from YOS workers.

Of the total referrals to the SCRP, 15% (20) were ruled out – either at the SCRP or subsequent initial EBP screening – for not meeting the inclusion criteria. This included families exhibiting lower-level, or fewer, difficulties, as noted on referral forms, for example “behaviour criteria for MST were not met” or “not at risk of care”.

Of the 85% (110) of eligible referrals, 9% (12) disengaged before the intervention got underway, variously due to perceived improvements in the family situation, a lack of motivation or other less positive reasons. For 2% (3), there was no capacity at the time they needed the service. Of the remaining 95 who did receive the service, 29% (28) had only just started the intervention, or were waiting to start by the end date of the evaluation recruitment phase, and so could not be included in the analysis.

Overall, 67 families were eligible for the evaluation sample. The majority (42, 63%) were allocated to FFT and 37% (25) to MST (see Table 10, Appendix C for a breakdown of EBP allocation by LA).

Characteristics and circumstances of the Step Change sample

Nearly two-thirds (40, 60%) of the evaluation sample were within the 14-15 age range, and 76% (51) were 14 or older. Nearly two-thirds (42, 63%) were boys, and just over half (35, 51%) were White British, followed by those with a Black/African/Caribbean background (10, 15%). One-quarter had a physical (5%), mental (8%) or learning (12%) disability and 22% were reported to have a statement of special educational needs (SEN[1]) at the time of referral. 73% of the 56 families for which data were available, were living with a single parent at baseline, of which 7% (4) were fathers. 21% (12) were living with both birth parents, and the remaining 6% (3) were living with other family members.

[1] Or an Education and Health Care Plan, which began to replace SEN statements in September 2014.

Most young people had at least one sibling (47, 87%). Overall, the basic characteristics of young people referred from the 3 Local Authorities were generally similar, with the exception of young people with SEN, the majority of whom had been referred from LA1 (10, 66%). See Table 11, Appendix C for an overview of the characteristics and circumstances of young people and their caregivers at baseline.

Background and children's social care involvement

Nearly half (31, 46%) of the young people had been involved with social care for at least 3 years. For two-fifths (26, 39%), their first referral had occurred between 5 and 15 years prior to Step Change. The most common reasons were maltreatment (25, 37%) and family dysfunction (22, 33%).

There was also evidence of multiple referrals, with 46% (31) of young people having between 2 and 6 referrals within the 3 years prior to Step Change: data were gathered on referrals to children's services since April 2012, 3 years prior to SC being introduced, suggesting recurring difficulties that services had been unable fully to address. This was evident within the views of those families that were interviewed, some of whom expressed feelings of dissatisfaction with the level of support they had received, and of having "been bypassed in the system all these years" (Parent):

> This is half of the trouble, we weren't given any support, this is why this has happened now…[the child] blames social services...he says "if they'd helped us mummy"…which is true, they didn't help us. (Parent, known to services for 4 years)

Almost three-quarters of young people (49, 73%) had been subject to a CIN Plan and over one-quarter (18, 27%) had been subject to a Child Protection Plan. A further 16% (11) had been subject to care proceedings during this time, most commonly due to maltreatment (5, 71%).

Over one-quarter (19, 28%) of young people had been LAC in the three years prior to Step Change. All had entered care during adolescence (10–16 years) with 57% (11) having entered between 14 and 16 years of age, echoing the national picture for the most common age range at entry to care (DfE, 2016). Four young people continued to be LAC at entry to the Step Change service, suggesting that the focus of the intervention in these cases was prevention of placement breakdown or reunification, rather than preventing entry to care.

There was evidence of children's social care involvement with other children in the household as well, with 27% (18) of young people having at least one of their siblings registered CIN. A further 18% (12) had siblings on the child protection register and 9% (6) had at least one sibling in care at the time of referral to Step Change.

Reasons for referral

A further indication of the level of need within the sample was evident in the reasons that young people and families had been referred to the service, and the nature of their difficulties at that time. Evidence of domestic violence was prevalent, affecting at least half of the Step Change families (34, 51%). Around two-fifths of primary caregivers had mental health difficulties (26, 39%) and at least 16% had difficulties related to substance misuse. Existing research suggests that together, these 3 factors present an increased risk for maltreatment (Brandon et al., 2010).

Young people's emotional and behavioural difficulties

Data collected for the Step Change referral form suggested that young people were presenting with considerable difficulties. In terms of individual risk factors, most of the young people (53, 80%) had displayed aggressive or violent behaviour in the home and one-third (22, 33%) were engaging in substance abuse that affected their behaviour and/or their family relationships. Affiliation with anti-social peers was also evident within the sample (32, 48%) and just over one-third (24, 36%) had run away from home. Two LAs provided data on child sexual exploitation and self-harming, with at least 17% (12) experiencing the former and a fifth (14, 21%) the latter.

One-quarter of the full evaluation sample (17, 25%) had been involved in offending prior to referral. The number of offences ranged from one to 7, although the majority of young people had committed one or 2 offences (11, 65%). Education data were missing for one LA, but for the other 2, there was evidence of education disruption and disengagement prior to referral. Whilst most young people (56%) were registered at mainstream secondary school, 60% (40) had truanted and 42% (28) had been permanently excluded.

The number of risk factors indicated by the referring social worker or YOS worker ranged from 2 to 12, and most (41, 61%) were considered to have 5 or more. This was in addition to the global risk indicator (at risk of entry to care due to the young person's anti-social, challenging or offending behaviour), of which three-quarters of the evaluation sample (50, 75%) were considered to present with at referral.

The more itemised referral criteria of MST compared to FFT were reflected in the fact that the young people referred to MST by the SCRP were, in general, those that presented with a greater number of risk factors (Mann-Whitney N= 67, p=.029). Young people from LA2, meanwhile, presented with fewer risks at referral than those from LAs 1 and 3 (Kruskall-Wallis N =67 p= .014). This could be an indication that LAs were operating different interpretations of 'edge of care'. However, it should also be borne in mind that, for most of the evaluation period, another IP funded project was also operating in LA2, targeting young people with a similar range of needs. Unlike Step Change, however, it was not able to take referrals from those on the edge of custody rather than care, which the LA2 lead acknowledged could have skewed the referrals to Step Change

towards those from the Youth Offending Service presenting with potentially less complex anti-social behaviours rather than critical family breakdown symptoms.[2]

Given the focus of the project and the inclusion criteria, the range of difficulties within the Step Change sample is to be expected. However, the extent to which young people were experiencing multiple difficulties indicates the high level of need at baseline. In the interviews, young people and parents talked of the difficulties that had brought them to Step Change. The most common themes included risk taking behaviour by young people, family crisis and relationship breakdown, and physical violence and offending:

> I was staying out till like 12 o'clock at night, 1 o'clock in the morning and I was getting arrested, and then I went to Court, put on tag. (Young person)

> [The child] didn't go to school for months and, you know, here it was just real verbal and physical aggression…you get your house smashed up, kicked in the back of the head. (Parent)

> …just a complete breakdown…my reactions with [the child] were just verbally horrible… [the child was] very withdrawn, very angry…smashing things up and breaking things, very violent towards me. (Parent)

In some cases, a specific incident, such as being bullied at school, parental separation or bereavement, had triggered an escalation of behaviour that parents had found difficult to manage. For others, difficulties had manifested over many years: "It's just always been difficulties within the family" (Parent).

Taking up Step Change

The referral process

For three-quarters of the sample (51, 76%), the intervention started within a month of referral, half of whom started within two weeks. Most of the families interviewed found the referral procedure relatively smooth and efficient and felt well informed. In most cases social workers had discussed the intervention with the families and, in all cases, the referring worker maintained case responsibility throughout the project:

> …probably about 2 weeks, because they gave me a call, they introduced themselves, [social worker] gave me the background leaflet about, you know, how they can help. (Parent)

[2] Data on the source of the referral (for example, social care or youth offending service) to explore the validity of this suggestion were not initially recorded on the referral form and were therefore incomplete.

Although participation in Step Change was voluntary, many families felt that in reality they had little choice but to agree to the intervention due to the severity of their circumstances:

> ...it would never be my choice… it's like I feel someone referred me and I had to. If I refuse they're not gonna listen to me or something, and I was worried about [my child] …I don't want to lose her again, or see her in dangerous situations like that. (Parent)

In exploring the reasons for agreeing to Step Change, it was little surprise that many families were, to use their words, "crying out" for help and, having exhausted other options, felt they had "no alternatives" or "nothing to lose":

> I begged them for help; I begged for therapy, I begged for support. What [my child] needed was help…counselling and support, and we needed that help. (Parent)

> There were no alternatives; that was what we were offered. We were trying everything at the time, you know; [child] had a social worker, had a YOT worker; and this was something a bit different to that because it was, you know, to try and make life easier. (Parent)

Half of the parents interviewed (8, 53%) explicitly stated that their child "would have ended up going into care" had they not been offered Step Change at the time:

> I went to Social Services and said I couldn't manage her behaviour anymore, that they had to house her, cos at that point I felt we'd tried every port of call. (Parent)

> The alternative, well they've already put my child in care…maybe they would have continued to threaten to remove my younger children. (Parent)

Having agreed to the intervention, there was an element of cynicism amongst families about whether it would work: "I was reluctant…found myself very wary before I got involved…" (Parent). In many cases, feeling sceptical or pessimistic was grounded in negative experiences of earlier involvement with multiple agencies over many years:

> At the beginning, I didn't think it was going to work…I just kept thinking…we need to have therapy...we've had therapy with CAMHS but they just can't help. (Parent)

In most cases, however, any initial scepticism dissipated once the sessions were underway and in some cases families found themselves highly recommending it "to every single family who has a problem controlling their children's behaviour" (Parent):

> I was like "I can't take on any more appointments"...and they was like "[the therapist will] come in for 6 months". I was like, "6 months, no [but]… from that day I met her…I was like, "yeah, I need her in my life". (Parent)

> I disliked to get involved…because of my past with the social, but …if you want to have a happy family and…benefit your family then take [the EBP]. (Parent)

Use of Step Change

Data gathered on a follow-up sample of 57 families revealed that the average duration of the intervention was 17 weeks and ranged from 7 to 28 weeks, not all cases having closed by the data collection cut-off date. Of the families who had exited Step Change by follow-up (36, 63%), most of them had graduated having met all goals (23, 64%). One-third, however, (12, 33%) had disengaged from the programme after 1 or more therapy sessions. Despite attempts to contact families that had disengaged, we were unable to include any in the final interview sample The number of therapy sessions per family at case closure ranged from 2 to 54.

Many of the families who were interviewed felt that Step Change had ended at the right time, having developed the tools and support necessary to continue beyond the intervention:

> It was a way of life, so to speak, and we were well beyond that [support] by the time we'd finished the therapy. (Parent)

For some, however, there was concern that they had only just begun their journey to rebuilding family life and that Step Change had ended too soon:

> It wasn't long enough to actually have sustainable change, you know, it's kind of, oh that's working, oh you're gone. (Parent)

Young people's experiences and outcomes

Follow-up data on key variables such as entry to care and offending were gathered at a minimum 5 month post baseline time point, or formal end date of intervention if longer than 5 months. See Table 12, Appendix C for a summary of follow-up data. The standardised outcome measures (SDQ and SCORE-15) were gathered by therapists as the intervention was drawing to an end, as were the interviews with families. The data indicated that progress was being achieved for most of the families, though it remained early days for significant change to have taken place.

Entry to care

Follow-up data (see Table 2 below) showed that the majority of young people using Step Change did not go into care during the evaluation timescale (45, 80 %). A substantial majority (34, 61%) remained with the same caregiver. Of note, 11 (20%) young people continued to be, or became, LAC over the follow-up as a way of meeting their needs. Four (7%) had gone into residential care, one (2%) into foster care, one into kinship care, whilst 1young person had moved into semi-independent accommodation. Four young people were living with relatives or kinship carers at referral and although they became LAC they remained in stable living conditions with the same carers. The majority of the LAC group (8, 73%) had not been in care in the 3 years prior to Step Change, whilst 2

(18%) had been in care within 15 months prior to the start of Step Change. One of the 4 young people in care at entry to Step Change had remained LAC throughout.

Table 2: Entry to care at follow-up

Entry to Care	LA1	LA2	LA3	TOTAL
Valid cases at follow-up	24	12	21	57
Number who did not enter care by follow-up (n=56)	19 (79% of LA sample)	10 (83% of LA sample)	16 (76% of LA sample)	45 (80% of Step Change sample)
Number entered care by follow-up	5 (21% of LA sample)	2 (17%) of LA sample	4 (24% of LA sample)	11 (20% of Step Change sample)

Offending

Just over one-third of those with a history of offending had re-offended by follow-up (6, 35%). One young person with no prior evidence of offending had gone on to commit an offence over the follow-up period. Whilst on the surface this suggests little improvement during the intervention, on closer investigation, young people had offended, on average, within 2 weeks of beginning Step Change, arguably too soon to expect behaviours to have altered.

Young people's subjective wellbeing

The GCI was completed by 45 young people at baseline (67% of evaluation sample) and by 14 of a possible 57 (25%) at follow-up. The index comprises 16 items that, together, indicate how happy a young person is in relation to 10 specific life domains, such as family and home, as well as how happy they are overall.

At baseline, young people indicated that they were most happy with their relationships with their friends, as is the case in the general population. However, the mean scores across all of the domains were lower than those found in the general population of 10-17 year olds in the UK (The Children's Society, 2015), (see Table 13, Appendix C). This was confirmed by the overall measure of happiness, where 32% of young people scored below the midpoint of the scale and could, therefore, be described as relatively unhappy and dissatisfied with their lives at baseline.

Follow up analysis should be treated with extreme caution given the small sample size. However, the mean score for overall wellbeing at follow-up was higher, though there was some variation. 79% (11) of the 14 young people had higher scores at follow-up, 1 reported no change, and 2 had lower scores. Only 1 of these scored below the cut-off and could be considered unhappy at follow-up.

Overall, therefore, there was some indication that young people who had exited Step Change felt generally more satisfied with their lives.

Family functioning

The SCORE-15 was sufficiently well completed to be usable for analysis by 39 (58%) young people and 54 (81%) primary caregivers at baseline, of whom 15 (26%) young people and 18 (32%) primary caregivers also provided follow-up data. The lower the score, the better the family is seen to be functioning.

At baseline, scores for the young people ranged from 1.47-4.40 with a mean of 2.97. Whilst again, follow-up analysis should be treated with considerable caution due to the sample size, nevertheless the range had reduced to 1.13-3.20 with a lower mean of 2.49, indicating a trend towards more positive family functioning . Similar trends were also observed for family strengths, family difficulties and communication (see Table 3). Primary caregivers showed similar improvements in family functioning at follow-up. Overall family functioning scores at baseline ranged from 1.60-4.67 with a mean of 2.87. At follow-up the range was from 1.07-3.73 with a mean of 2.13.

Table 3: SCORE-15 baseline and follow-up scores

SCORE-15	Primary caregivers Baseline Mean (SD)	Primary caregivers Follow-up 1 Mean (SD)	Young people Baseline Mean (SD)	Young people Follow-up 1 Mean (SD)
Overall Family Functioning	2.87 (.76)	2.13 (.72)	2.97 (.71)	2.49 (.58)
Family Strengths	2.81 (.93)	2.14 (.87)	3.00 (.82)	2.18 (.77)
Family Difficulties	3.10 (.97)	2.17 (.87)	3.04 (.93)	2.66 (.73)
Family Communication	2.70 (.85)	2.07 (.77)	2.87 (.74)	2.64 (.72)

A paired samples t-test, conducted to compare baseline and follow-up levels of overall family functioning, showed a significant positive difference in the scores as reported by young people: $t(14)=3.90$, $p<.05$. A significant positive difference was also reported by primary caregivers: $t(17)=2.47$, $p<.05$.

While improvements over time in family functioning appear to be statistically significant, it is important to understand whether meaningful, clinically significant change had occurred. Interpreting clinical significance can be achieved by examining change in the number and percentage of cases reaching clinical cut-offs. Cut-offs and UK norms for the SCORE-15 are still in development. However, cut-offs identified in an Irish study (Fay et al., 2013) gave some indication of the size and nature of change experienced by the families in the current sample. Cut-offs are given for 3 groups: families functioning well; families with significant problems (i.e. young people were likely to have significant emotional and behavioural problems); and families with very significant problems (top 10% of family difficulties in the population).

For the cases where data were available at 2 time points, there were larger numbers in the functioning well category by follow-up, as reported by both young people and primary caregivers (Table 14, Appendix C). These findings suggested that, while not all families were reported to be functioning well, the improvements experienced by the families in this sub-sample were for the most part clinically significant. This is in line with the aims of both MST and FFT where the remit is not to eradicate all family difficulties but to empower families to relate better with one another and increase their ability to cope with stressful situations.

Emotional, social and behavioural difficulties

The SDQ was completed by 42 (63%) young people and 51 (76%) primary caregivers at baseline, of whom 11 (19%) young people and 16 (28%) primary caregivers also completed an SDQ at follow-up. This data indicated that the young people were experiencing high levels of difficulty in relation to their emotions, concentration, behaviour and ability to get on with other people. Unsurprisingly, these young people experienced much greater difficulties on average, in key areas of development, when compared to other children of a similar age living in the UK. In many cases the scores of the Step Change sample differed from the national sample by more than 1 standard deviation (See Tables 4 and 5 below).

Scores on the SDQ can also be analysed in relation to bandings or thresholds that represent the proportion of children in the general population with similar scores: for example, 80% of children in the UK score ‘close to average’, 10% score ‘slightly raised’, 5% score ‘high’ and a further 5% score ‘very high’. Children with scores in the high and very high range experience a significant pattern of difficulties that suggest they would benefit from specialist help.

Many of the young people in the sample, in line with expectations for the target group, fell into the high and very high bandings at baseline, particularly in relation to their total difficulties and conduct problems (see Table 15 and 16, Appendix C). However, it is notable, given the eligibility criteria for the service, that there were a number of children who scored in the ‘close to average’ range at baseline on these 2 subscales, raising the question of whether it is effective, and cost-effective, to offer these young people the Step Change intervention.

There was some difference between the young people’s and parents’ perceptions of the young people’s difficulties and conduct problems. This is not uncommon and has been found in similar studies of adolescents on the edge of care that have used the SDQ (Biehal, 2005). Even when taking the lower scores reported by young people, in the current sample, the level of difficulties still exceeded those reported in UK populations.

A paired samples t-test was conducted to compare baseline and follow-up levels of total difficulties. No statistically significant differences were observed in the scores as reported by young people, though proportionally fewer young people were presenting at follow-up with clinically significant difficulties (see Table 15 and 16, Appendix C).

Collectively, the findings from these measures are promising, but there are a number of important caveats to bear in mind, in addition to the small size of the follow-up samples, which are outlined in section 4.

Table 4: Baseline SDQ scores compared to the British general population

SDQ subscales and total difficulties	Step Change Parent report (n=51) Mean (SD)	British norm (11-15 year olds) Mean (SD)	Step Change Youth report (n=42) Mean (SD)	British norm (11-15 year olds) Mean (SD)
Emotion	5.1 (2.6)	1.9 (2.0)	4.6 (2.6)	2.8 (2.1)
Conduct	5.6 (2.6)	1.6 (1.7)	4.8 (2.5)	2.2 (1.7)
Hyperactivity	6.8 (5.6)	3.5 (2.6)	6.5 (2.4)	3.8 (2.2)
Peer Problems	3.3 (1.8)	1.5 (1.7)	3.2 (2.0)	1.5 (1.4)
Prosocial	5.8 (2.2)	8.6 (1.6)	4.9 (1.7)	8.0 (1.7)
Total Difficulties	20.8 (6.8)	8.4 (5.8)	19.1 (6.6)	10.2 (5.2)

(source of norm data: Meltzer et al., 2000)

Table 5: Follow-up SDQ scores compared to the British general population

SDQ subscales and total difficulties	Step Change Parent report (n=16) Mean (SD)	British norm (11-15 year olds) Mean (SD)	Step Change Youth report (n=11) Mean (SD)	British norm (11-15 year olds) Mean (SD)
Emotion	3.5 (2.4)	1.9 (2.0)	4.1 (2.5)	2.8 (2.1)
Conduct	3.6 (2.0)	1.6 (1.7)	3.9 (1.8)	2.2 (1.7)
Hyperactivity	5.8 (2.5)	3.5 (2.6)	4.4 (2.6)	3.8 (2.2)
Peer Problems	2.9 (1.7)	1.5 (1.7)	3.9 (1.8)	1.5 (1.4)
Prosocial	6.7 (2.7)	8.6 (1.6)	6.1 (1.3)	8.0 (1.7)
Total Difficulties	15.8 (7.0)	8.4 (5.8)	16.3 (6.5)	10.2 (5.2)

(source of norm data: Meltzer et al., 2000)

Perspectives of young people, parents and workers

To supplement the outcome measures and offer a more nuanced insight into whether Step Change made a difference, we drew upon interviews with young people (n=13) and their parents (n=15), together with feedback from the referring social or YOS workers (n=14) and the Step Change therapists working with the families (n=7).

In almost all cases, parents talked positively of the impact that Step Change had on their family life: “It’s made our life bearable again…it’s a million times better”. Progress was

noted in overall family interactions and communication, as well as their child's behaviour within and outside the family home:

> [Improvements in his behaviour] were maintained, it was more consistent…quite a few changes, he's cut down on his cannabis use, which I didn't think was ever gonna happen, now he's talking about stopping. (Parent)

> …the physical violence has stopped completely…. I still get the tantrums but nowhere near as bad so although she's still a moody teenager, it's the way that I deal with things. (Parent)

> Her behaviour, you know, the house is peaceful, happy, tranquil. I just think that, you know, she's now within normal range of any teenage girl; she's quite calm, so it instils confidence that, you know, we won't need such interventions or, or hopefully not, fingers crossed, but, if we do we'll be better equipped to deal with it. (Parent)

Some parents reported that the main change was their own ability to manage family difficulties better, acknowledging that some difficulties and risky behaviour were likely to persist as children progressed through adolescence:

> She still now and again has a wobble, no-one's perfect, everybody gets angry, but because I know how to handle it, … we both kind of separate, calm down, and then I come back and say, you know, I wasn't happy with why you did this, this is the reason. So yeah, that was all part of what I've learnt through Step Change. (Parent)

Equally, young people commented on improved family relationships, most commonly recognising a change in their parent's mood and response towards them:

> It's like she's not as upset, she's more happy…she's changed a lot of things, we just get on now, I don't even know how to explain…just feels perfect now. (Young person)

> [The therapist] helped my mum… her moods weren't as low... helped her find ways to sort of just calm down. (Young person)

For this young person, recognition of her mum's efforts to support her had led to a change in her attitude to school:

> My mum really put in a lot of effort to get me a place in the school that I wanted to go to, and I realised that and I said, "Oh there's no point in staying at home cos mum worked hard for this". So I definitely think that's contributed to why I'm going to school a lot more now. (Young person)

What worked?

When asked to describe what it was about Step Change that had made a difference, a number of common factors emerged.

Relationship with therapist

Central to the perceived benefit of Step Change was the relationship that was formed between families and the therapists. Most families appreciated the opportunity to build a trusting and positive alliance with the therapist. Feeling better understood, supported and free from being judged were common sentiments amongst parents.

Perceiving therapists as independent of children's social care and YOS, some parents and young people considered them a more impartial or benign presence in their lives than social workers. This was echoed by referring social workers: "families do not feel threatened as this is an external service". Some parents talked of therapists as a "family friend" or "my guardian angel" demonstrating the strength of the relationship; the high regard in which they were held, and the effect they could have on family circumstances:

> …everything's calm and, you know, [the therapist] doesn't judge us, she's basically a …very big part of our life...I feel quite calm when she's there…she's…the first person I'd want to pick the phone up to... (Parent)

> …like I love [my therapist], she's good to work with, but then we had our social worker, it's like they're just annoying… (Young person)

> …out of a 10 I'd give [my therapist] 8, 8 and a half… (Young person)

> [My therapist] seems to have the knowledge, the tools, the professionalism to give sound advice and I'm really impressed, it's been the best help that we've received. (Parent)

Parents described therapists advocating for them when dealing with other agencies, driving them and their children to appointments and mediating between wider family members. Where therapists had become a big part of family life, there was sense of sadness when it was time for them to move on:

> One day, she said "this is the last meeting". And I said "No". Well I guess we didn't really need her anymore…it's a bit like Nanny McPhee, at first we didn't want her but we needed her and now we don't need her but we want her… (Young person)

Consistency, accessibility and intensity of the therapy

Families evidently valued the consistency and intensity of contact, for example the frequency and accessibility that they had with their therapist:

> It was a lot better than what we got from Social Services…they kept changing our social workers…they'd ring us up and say, oh we've assigned another social worker and you'd be like, oh no, not another one… (Parent)

Having regular meetings within the family home, sometimes several times a week, with the same therapist seemed to provide some momentum where issues could be addressed in real time rather than retrospectively:

> I think it was the intensity that [was different], yeah, it weren't forgotten…when you meet other people once every 3 months, it's like they're just there because, you know, but with [the therapist] it was like, quite intense, you know? (Parent)

> If I want to pick up the phone, like I can just talk, I, I don't feel like, oh sorry to bother you, I just phone her, we text each other and she'll say, how's it going? (Parent)

This was further facilitated by the opportunity for families to contact their own therapists out of hours, as and when difficulties arose. Referring social workers acknowledged that this was an added advantage that was not always possible within their own service:

> Families [are] offered the support and time that cannot be offered by allocated workers because of the overload of cases. (Social worker)

> The fact that [the family] could have 24 hour support even on the weekends was helpful because [the young person] would abscond on the weekend and other professionals do not work then. (Social worker)

Empowering families

For some families who had felt disempowered by previous service interventions, Step Change gave them back a sense of control over the support they were receiving, as well as the difficulties they were experiencing. In helping families to develop greater autonomy by identifying their own goals and solutions to their difficulties, as well as empowering them with improved parenting skills, there was a general sense that therapists were on their side and that Step Change was a journey they were on together. In this sense, Step Change felt more like something that was done with them rather than to them. Here again, families made a distinction between the Step Change intervention and the types of support they had received in the past:

> At first I just looked at it as another part of Social Services…I didn't realise she was going to be there for me and my children, I thought she was just gonna be someone else that'd come in and say, right you've got to do this, you've got to…but not at all, totally just the way she worked, little things she did with you. (Parent)

> [The therapist] contributed because of the way he explained to me how to talk in a different way, you know, go about it in a different way, give me different options, drivers, goals…really sat down and talked. (Parent)

The collaborative and empowering approach was seen as crucial for families to sustain progress beyond the end of therapy:

> If it's not developed collaboratively with the family it's unlikely to be successful… [goals] have to be realistic and achievable for families, where they do not have to rely on people outside their natural ecology for them to work. (Step Change therapist)

A sense of empowerment also came from the new skills and strategies that families were developing through the therapy:

> [The intervention] gave me an inner strength and a power…it has made me so much more confident…my confidence at the beginning was so low that even just...confronting [my child] over something she'd done… it was scary… saying 'hey this isn't ok'…but the more you do it then you realise that you can do it… (Parent)

> (The intervention) actually gave you the tools…whatever you need, to maintain some sort of sanity. Before, [other services] are coming and blaming and pointing fingers, make you feel like you're in the wrong when you're just having a bit of a problem, so instead of coming in and blaming and saying how you know, how useless you are, [the therapist] comes in, helps to show you the way. (Parent)

Some families commented on the wider benefits that working with the therapists had brought to the entire family. This was expressed in terms of a reduction in their child's behavioural difficulties and also the impact of improved parenting skills:

> I've got other children and even though I was referred just because of one child … I was still able to discuss [other children] in the meeting you know it wasn't "it's got nothing to do with that child we can't help you with that one", I still got the advice, so I believe that helped me with what I was doing. (Parent)

Where Step Change appeared to work particularly well, therefore, was the ability of therapists to get to know the families well: understand their difficulties, and build trust by consistency of contact, as well as empowering them to develop their own ways of repairing family relationships. This more intensive, personal, independent approach was seen as a useful lever for encouraging the collaboration of families that might have felt let down by services in the past. In some ways the intervention offered a way of restoring the families' confidence in professionals:

> [It works] by validating family struggle, respecting families…a lot of families have felt judged and demonised or let down by professionals. Using a strength based way and showing them a different type of relationship with professionals... [Step Change] is building bridges between social services and families they work with. (Step Change therapist)

What didn't work?

A minority of families (4 out of 15, 27%) felt that the Step Change intervention, or particular components within it, had not worked well for them. Sometimes, the same

factors that had worked well for others were cited as reasons for their dissatisfaction. For example, the intensity of the interventions proved too much in some cases, especially when families had weekly commitments with other service provision as well, leading to a sense of overload:

> I thought it was too much, I was thinking [my child] is going through all this, does he need another thing? He's got YOT work twice a week, he's got to go to this, that…he's told me "I'm going to all these things, dad, it's not doing nothing for me. (Parent)

For parents in greater distress, it was felt that the Step Change approach of encouraging them to find their own solutions might have proved too challenging:

> Where parents did not engage…some families feel helpless and the process where they need to come up with their own solution might not work. (Social worker)

Step Change therapists cited a lack of commitment or co-operation from families and sometimes other professionals or organisations as barriers to the intervention's success:

> It is a commitment from families and the service to work together. The parents and carers are the key to the change, if they are not in a place where they are able to engage with that process then it is unlikely to be successful. This could have been explained more clearly to families at the referral stage. (Step Change therapist)

> Can't get them back into education….no school within the Borough is prepared to accept the young person. (Step Change Therapist)

Parents also highlighted the lack of engagement from their child as the reason that the intervention had been less successful:

> No, it wasn't helpful; because if he's not engaging, nothing's helpful…you know, if they're the best intentions in the world [but] he's not engaging, it's not helpful. (Parent)

Some professionals considered a particular strength of MST's approach, (which did not require young people to take part in the sessions) to be its ability to bypass the difficulties of young people engaging in the intervention. One or 2 young people, however, expressed some displeasure that they had not been involved:

> I just didn't like the fact they were coming to my house..once a week and talking to my mum….. I wasn't happy they got to know stuff about me while I'm not there. (Young Person)

One young person felt that the Step Change intervention had a negative impact on her mum, and had caused more stress within the household:

> I think it might have erupted [sic] my mum, every single session during that hour space, she'd smoke about 3 cigarettes, scream and shout and cry….she'd be angry

> sometimes…felt she got blamed for lots of things in the session…she was angry with [us] afterwards. (Young person)

The implementation evaluation

The findings in this section have been synthesised to provide a narrative on the key lessons learned, and barriers and facilitators of implementing the innovation, including the processes of set-up, initial implementation and ongoing sustainable provision.

Nature of bid and bidding process

With hindsight, there was a consensus among stakeholders that the nature of the bid itself was unrealistic and the bidding process was rushed, and did not allow sufficient time to think the proposals through properly. As a result, as those involved in the Operational and Strategic Boards acknowledged, the project proceeded initially on mistaken understandings of the degree to which LAs understood and had agreed to all the details of the bid:

> I'm not sure that the LAs fully understood what they were committing to … even though Chief Execs and Directors had signed up for a 5 year programme, it was very evident that senior staff didn't understand that.

In governance terms, this was seen to have affected the progress of implementation, especially the appropriate prioritisation of tasks:

> The way…bidding processes go, people don't know whether their bids are going to be successful so the extent of ownership…that they have to the proposal can be quite tenuous…[when it] was actually going to be happening, they were [not] clear about what they'd bought into. In 2 of the LAs there were changes in the key personnel who had the made the decision [to] participate. So, I think the [AfC] team underestimated [what] was going to be required to build a collective culture across the LAs and get them to feel that they owned Step Change.

The overriding difficulty with the bid during the set-up phase was the question of its financial and practical sustainability in the long-term, which led to the service changes outlined earlier (removal of TFCO and Sustainability Workers, reduction in SCAs). Some of the least practical implications of the bid could have been mitigated, in the views of the participants, by the greater input of operational expertise from an earlier stage in its development.

Implementing the core and innovative components of Step Change

Partnership working

The Step Change model involved 3 LAs, as well as 2 EBPs, together with AfC and additionally, for this initial trial period, separate funding and evaluation organisations. Effective partnership working was therefore at the core of the successful implementation of the service – but was also a major challenge. The complexities of juggling the different systems and requirements of all these organisations was clearly evident in partners' responses when asked to address what had worked well or less well:

> …it's been clunky and I think that's partly because it's always difficult when you're working with a range of organisations, all of which have got their own political pressures, and the profile of each LA involved in this is very different.

Whilst the 3 LAs and AfC were equal partners or owners of the project, in principle AfC, as the providers of the service, retained most of the grant. There was clearly a perception that the LAs felt a sense of inequality in the ownership of the project:

> …the key owners are AfC and the 3 Authorities and that was so unequal…we didn't start off in similar places…we did not have the buy-in that we thought, and as soon as we talked about sustainability, those cracks showed really.

Overall, the AfC team were strongly commended for their hard work and commitment in managing the project and for holding on to the innovative ambition of the project:

> AfC has been working really hard I think to try and keep that bigger picture alive and work with the new individuals as they come on the project.

> [AfC] had the vision and the energy and the drive and the resource and they really worked incredibly hard.

The difficult circumstances within which the project had to be managed, however, as well as pressurised timelines, affected the quality of communication between partners:

> The speed at which we've been doing stuff has meant that some of the things I would have wanted…the consultation and engagement - we've had to blast through some stuff, and that doesn't help with partnership arrangements.

One of the reasons these 3 LAs in particular came to be involved in the project is because they were perceived by AfC to have existing joint working links through membership of the West London Alliance (WLA) that would assist with the development of an integrated operating system. However, in reality, this alliance did not represent much commonality between the LAs:

> They're not the 2 boroughs I would really have gone with. If you are going to go with a tri-borough approach, you would go with your neighbours. So [LA name] is fine, but [the other LA] is nowhere near. So it doesn't make sense…We don't have any connectivity with that LA generally…only really through the care placements.

The scale of the operational challenge to co-ordinate multiple partners and systems was most acutely played out in the attempt to pull together a joined-up protocol for data sharing that was both technically practical, as well as meeting the legal requirements of the Data Protection Act (1998):

> …where [the partners] had to adapt or flex their own arrangements [to] produce common data systems that were compatible with the LAs' own data systems, confidentiality agreements, or technology…it was incredibly difficult…and it's taken up a disproportionate amount of time to overcome these logistical and procedural barriers.

There were also reflections on the structure of the service and whether it was the optimum model possible – in particular, whether an external agency, mediating between the LAs and the EBPs added value. Some frustration was evident on all sides about the implications of mediators for efficient communication, but this was countered by a recognition of the amount of work that the LAs were relieved from having to undertake:

> …one of the barriers is the different systems that this project has entailed, and…trying to introduce a fourth system on top of 3 existing systems, for example with information governance or sharing, and indeed the data collection - one of the problems is that it introduces additional burdens and I think that is a barrier both now and potentially moving forward because that in itself may not add value for money.

> …it's two-fold in a way…it was a bit frustrating when we wanted direct responses to certain things, particularly around the details of information sharing...[But] the huge benefit of having AfC as the provider - all of that time and effort around all of the stuff to tick the licence box if you like, the burden of that wasn't on the authorities…that's the huge benefit of us not direct commissioning [the EBPs]…things that AfC led on, the management, the recruitment, I think it would have been very challenging for us to provide in-house if you like.

Reaching the intended target group

Discussions among the operational and strategic leads during the set-up phase of Step Change implementation, at which the evaluators were present, suggested that the target group of young people might vary between LAs and, in some cases, represent a looser interpretation of the concept of 'edge of care' than was the case in the bid. Data from both the interviews and the observation supported these indications, as did the outcomes data discussed earlier:

> [Step Change] is for young people that could be on the edge of care [but] we're not just looking at edge of care anymore.
>
> I think our idea of what edge of care means is still sort of evolving. I think initially…the ideas were very much crisis point - if they don't go to [one of the EBPs] they're definitely going to be in care the next day or the next week. But from conversations with people here and other programmes who've had FFT and MST, the feedback is that the effectiveness of FFT and MST at that actual crisis point is sort of debateable perhaps. And that actually it's planned intervention, even though it's for young people exhibiting really quite serious behaviours…So [we are] looking at widening the threshold possibly.

Another key driver was the need to boost referrals to the service in the short-term in order to supply enough cases to meet the training requirements of the EBPs:

> We all wanted to maximise the referrals, to give it the best possible go. So it was not entirely resource-driven, it was also about wanting to have as many families as possible get through the programme to get the best picture of how effective it was.

Step Change Advisors

Protracted negotiations around the merits and appropriate workload of the SCA role meant that what emerged as the very important task of service promotion within the LAs was under-resourced during the critical pre-launch period:

> It's unfortunate that the SCA post has only come to fruition really after the programme had launched - we were already working on communication and establishing referral routes, we'd had to do a lot of that work already.
>
> [The LA senior leads were] really sceptical about the SCA role…I think they're now seeing how significant that is in terms of building a link between LAs and Step Change work…that's starting to work well.

Single referral pathway

The SRP was a cornerstone of the innovative nature of the bid. With the SCAs in place, working with LA social care teams, in the first instance, to identify suitable referrals, it was intended that the SRP would have 'oversight of the range of all eligible cases across the 3 boroughs' (AfC et al 2014, p18), and that referral processes would be standardised. Here, again, the variability of the systems in each LA, and the impracticability of changing them, was perhaps underestimated, and different practices continued to operate:

> …the LAs have a different way of doing their local panels…so [one LA] has a local assessment panel which we would like our SCAs to sit on [but] they decide who they want to put through to Step Change [first] and then they meet separately with the SCA

to talk those through. In [another LA] they don't have the referral panel so [the Operational Lead] goes through the referrals herself. And in [the third LA] the SCA or the supervisor attends the panel and that's useful.

[In two of the LAs] the decision has already been made in a way even before it goes to [the LA] Panel. The [social] workers identify the case, they would probably have a conversation with their manager and they may have a conversation with me so it's kind of decided that it is a case for Step Change. Then it goes to the [LA] Panel and then it goes to the Step Change panel.

As was pointed out by one participant, preliminary assessments could therefore be made by people who did not necessarily have sufficient expertise in the EBPs to accurately judge suitability.

Operational implications for EBP therapists

Travel

The model, as originally planned, provided for each of the therapists to be based in one LA. However, in the early stages of delivery, as capacity was building, therapists had to be deployed more widely, and indications were that a degree of cross-borough working would become an inevitable part of normal practice:

… some of the therapists are having to work across the Boroughs … time wise, they have a very difficult schedule and traffic is really bad.

[We] were told that you're given a borough and that's the borough you'd be working in [but] now you're cross-borough working, and the time it takes to get from one borough to the next is phenomenal…it can take up to 2 hours…So you have to be flexible with the way that you work.

Case management and information systems

The reality of multiple information systems, together with concerns about data sharing protocols, impacted significantly on therapists' case management processes:

I think the hugest challenge with Step Change [is] the amount of systems that we use …you're dealing with AfC's data protection plus the national standards, then the 3 different Borough's policies…and then you've got the MST and FFT systems…the data protection I absolutely get [but] somebody goes, "Case Number 525665" and I'm like, "I have no idea who that is" and then if I need information when I'm out and about, like a telephone number, I have to access the computer system at AfC remotely because it can't be anywhere else.

These difficulties significantly increased therapists' administrative workload, which was sometimes exacerbated by poorly functioning technology and IT support:

> … the technology we've been given has not functioned very well … and they don't have enough IT guys from what I can see, so you can wait 2 weeks to get something fixed.

Issues of sustainability

Step Change ceased operations at the end of October 2016 when the Innovation Programme funding came to an end. Despite initial commitments to implement and test the programme over a 5 year period, the LAs, and thus AfC, were unable to sustain the project beyond the Innovation Programme timeline.

Over the course of the project, each LA developed different positions in relation to the future of the service: one wanted to continue investing in Step Change, another was financially unable to continue, and the third wanted to invest in MST only, but needed to be in partnership with other LAs to reach a viable level of demand for the service.

The 2 LAs that wished to continue concluded that, between them, demand for the service would not be sufficient to support a viable MST service. Efforts to identify another LA to partner with did not progress rapidly enough to secure commitment by the time a decision on sustainability was required. Without investment by the Las, and holding all of the financial risk, AfC were unable to continue the service.

Some of the barriers relate to themes that emerged in our analysis of the overall process of implementing Step Change, whereas others appear to have arisen directly as a result of the discussions about future roll-out. The rationale for each organisation's decision, key barriers to further investment, and factors that may have enabled a different outcome for this project are briefly outlined below.

Insufficient time to fully test and evaluate the service

All partners acknowledged that more time was needed to determine what impact the service was having, particularly in relation to LAC rates and associated cost savings:

> I think the challenge for us was having enough evidence…in a very short space of time to be able to convince ourselves and elected members [to invest] in these programmes over and above our internal services…the short term nature of the funding…prevented the LA from being able to secure that evidence and understanding to be able then to look at future funding.

A catch 22 situation arose whereby more time was needed to evidence the effects of the service, but the LAs were not able to invest in, and support, continued implementation

without evidence of impact. In order to address this gap, and support the decision-making process, a number of exercises were undertaken by AfC and the LAs, including an internal review of the progress of cases referred to Step Change, and an additional piece of work with social finance to model potential cost-benefits. Despite the very encouraging findings, this work could not be regarded as sufficiently authoritative, in research terms, to form the basis of significant funding decisions.

Context of austerity

Although FFT and MST are typically viewed as expensive interventions requiring significant up-front investment, research does highlight the large financial savings that can be achieved by diverting young people from care and custody over the longer-term. Despite a general acknowledgement that the interventions may well have produced positive outcomes and savings to the LAs over the 5 year period, more immediate cuts in the funding of children's services presented a significant barrier. As 2 of the operational leads noted, budget considerations significantly hampered their ability to fund further roll-out of the project:

> …the programmes are expensive, and all LAs are experiencing cuts and massive pressures at the moment. So…we were facing an uphill battle anyway to be able to secure and continue funding and commitment for it.

> There's been more and more pressures on children's services' budget to reduce our spend, and therefore any commitment to continuing the programmes was always going to be very difficult to argue a case for when we've got statutory duties [and] that's all we're able to deliver at the moment.

Lack of strategic buy-in

From AfC's perspective, sustainability was built into the bid as a pre-requisite, and commitment from the LAs was for a 5 year programme of work. As discussed earlier, this turned out to be a mistaken assumption.

Responses to the EBPs and their components

The differences between the EBPs were both real (for example, in terms of cost and intensity of approach), and perceived. For example, one LA developed a bias towards a particular EBP, but acknowledged that administrative problems and delays in setting up the other EBP may have contributed to that perception. These differences were among the factors leading the LAs to reach different positions about whether they were interested in commissioning the whole of Step Change, or simply one of the EBPs alone – or even whether there were elements of the models that could be effectively incorporated into social worker practice.

> …going forward, we're looking at that balance of the cost and some of the challenges that an EBP poses, whether it's worth that investment in the long term, or whether you can achieve the same outcomes using people with a clinical understanding and a therapeutic background to deliver the same types of interventions.

Matched funding

Matched funding has been adopted in subsequent rounds of innovation programme investment and one respondent identified this as a useful method for encouraging shared ownership and ongoing investment:

> I think the model of what they're [DfE] doing now in terms of the local authorities having matched funding has probably made it more difficult for people but I think that actually that's right, because then there's some realism within the local authorities that this isn't a freebie, it's not a handout.

Flexibility in procurement regulations

It was noted by one respondent that previous government pilots have been accompanied by flexibility in procurement regulations in order to enable innovations to be sustained beyond pilot funding. As AfC were already providing MST and FFT services elsewhere (albeit not within a joint structure like Step Change), technically the project could not be classified as sufficiently innovative within current guidelines for competitive tendering. In the circumstances, this was experienced as a frustrating, and overly restrictive, constraint.

Final thoughts from the operational board

Perspectives of operational board members were gathered via wave 2 qualitative telephone interviews. Themes emerging from an analysis of their responses suggest that although the project was coming to an end, a great deal of learning had been achieved, and all partners reported a largely positive experience.

A key theme was the recognition for the teams of therapists, in terms of their quality of work in each of the LAs:

> What we would have liked to have done with Action for Children is the continuation of Step Change, because I think the MST team is actually fantastic, and we've had really good therapists.

> The feedback from [EBP trainers] has been that these were 2 good teams whose trajectory would have been that they would have been very good teams delivering these programmes, despite some of the challenges that we had in terms of geography and stuff.

> It's a well-designed programme that had to quickly mobilise, it was delivered to high quality but strategic factors had a really significant impact on its long term success.

A second theme was related to the insights that Step Change had generated for the organisations, in terms of what it takes to deliver evidence-based programmes in children's social care:

> I think we've learnt a lot about what it takes to set up evidence based programmes, the length of time it's taken and the resource intensiveness of trying to do all that. And the challenges of working across 3 boroughs when you're doing it has been a real interesting journey and very challenging at times.

> …actually in terms of Innovation – and remember it was an Innovation bid and therefore it was about trying some stuff, I think running the 2 programmes alongside each other was really interesting in terms of learning about some of the differences, the similarities, some of the – we worked through some of the anxieties, and therefore all of that learning has been absolute gold dust.

Final thoughts from the frontline

A follow-up survey was administered to Step Change personnel (therapists, supervisors and the Step Change Advisor, n=13) in addition to referring social workers in the LAs (number unknown as administration was delegated to the Step Change operational leads). Responses (some incomplete) were returned from 7 Step Change personnel (mostly therapists), 9 social workers and one youth offending worker.

Respondents were asked to rate a number of aspects of the project on a satisfaction scale and, as Table 17 in Appendix C shows, among the questions asked of the respondents, the highest rating was recorded for the practice of communicating family progress between Step Change and LA staff, followed by the process of referring families to SC. Dissatisfaction scores were generally low, but there were one or 2 aspects where a neutral response outweighed both the positive and negative responses, such as the therapists' experience of working with the LAs.

When asked to rate their overall experience of working with the Step Change service on a scale of 1(extremely poor) to 10 (extremely good) (n=16), 10 (63%) returned a rating of between 8 and 10, and a further 4 (25%) returned a rating of 6. The lowest rating was a 4. This data indicates the respondents' view that the Step Change service was at least good and for many, extremely good.

In answer to the question of the benefits to the LAs of having the Step Change service, referring social workers in particular highlighted its accessibility and intensive level of therapeutic input, both of which were described by one as 'beyond the capacity of the social worker to provide', and by another as 'taking some of the pressure off the social

worker'. The independence of the service from the LA was identified by referring social workers and therapists as a benefit, in that families found it 'less threatening' as a result, and were more likely to open up to the therapist.

When asked to think about any disadvantages, the most frequently mentioned factor was the funding arrangements. This may be unsurprising, given that the survey was administered around the time of the decision to discontinue the service. Nevertheless, whilst some acknowledged that the difficulty in stretching LA budgets to cover the high cost of this type of intensive intervention could be offset by the associated reduction in the cost of care, it was the instability of the funding stream that was most regretted. One social worker reported that this was the second time in her experience that funding had been withdrawn from a project that was working well because it was dependent on a time limited, external source of funding.

The economic evaluation

The economic evaluation is partial and largely descriptive due to challenges in data collection and the need for a longer time-frame to analyse any impact on care entry rates, length of stay and placement stability. Data from the Service Provision Checklist are available for 15 families and provides some insight into the frequency and costs of contact between young people and families' and their Step Change therapist. It also offers some information on the costs of contact with additional services in 3 months leading up to their interview with the research team.

The costs of contact with FFT and MST therapists

As expected, all of the families had been in regular contact with their Step Change therapist in the past 3 months (see Table 18, Appendix C). Families participating in FFT had fewer and shorter contacts than families in receipt of MST. This likely reflects differences in the design of each intervention, with MST offering greater intensity, and therapists available to families 24/7. As a result of the differing intensity, costs associated with contact between families and MST are higher than those for FFT. Unit costs for FFT and MST are presented in Table 19 (in Appendix C). The estimated costs of contact with Step Change therapists are presented in Table 20 (in Appendix C). The differential is in line with estimates of the overall unit cost of FFT and MST to families in the UK (£3465 and £9732 respectively, see investinginchildren.

The costs of additional services

The young people and families supported by Step Change face significant and multiple difficulties and are in contact with a number of different services. In the absence of precise, consistently and centrally recorded information on those services, including their

nature, frequency and duration, it is difficult to estimate their costs. The data from the SPC suggests that self-report via families yields relevant information that can be used for this purpose and may therefore prove more fruitful for a future economic evaluation than the analysis of routinely collected data.

Unit costs of additional services are presented in Table 21 (in Appendix C). Table 22 (also in Appendix C) suggests that young people and their families were typically having contact with a number of other professionals alongside their Step Change therapist during the latter stages of the intervention. Those contacts appear to have been brief and on average low cost: Table 23 shows the estimated costs of additional services accessed by the sample families. This may reflect guidance set for MST and FFT with regards to limiting additional contact with other professionals where possible. Without comparative data, we are unable to establish whether there has been a reduction in contacts with additional services: however, there is a strong suggestion from the qualitative interviews with families that contact with other professionals did reduce during the time they received either FFT or MST.

It should be noted that unit costs are from unit cost guidebooks, as per innovation programme guidance for this project, and, although costs have been adjusted for inflation, London multipliers have not been applied. The costs therefore may not represent the actual costs to the LAs involved in Step Change.

While contact with additional services may appear to be minimal in the data gathered via the SPC, it is clear from the LA data that social workers remained actively involved in case management and remained in regular contact with families throughout the Step Change intervention.

Data on social worker contact provided by LA2 and LA3 for cases where information was available at both baseline and follow-up, n=31, suggested that, in contrast to services from other professionals, frequency of family contact with social workers was relatively stable over the baseline and follow-up periods (See Table 24, Appendix C). This is surprising given that MST and FFT therapists are generally expected to temporarily take on the role of lead professional while the intervention is under way. Operational leads from the LAs contributed explanations for this:

> Now that may have been appropriate because of safeguarding reasons, but what it also meant was that Step Change didn't have the impact of reducing the involvement of the children's services in the cases. So it didn't reduce the number of times the social workers were necessarily seeing the families or the level of resource we were providing. (LA Operational Lead)

> I mean, I think it is a consideration in terms of …whether or not an evidence based programme such as Step Change would mean that savings would be realised as a

> result of a lesser involvement in social care services going into families…I think there was a concern about not wanting to withdraw services too quickly from a social care perspective. (LA Operational Lead)

It would be important in any future economic evaluation of Step Change to capture the costs of social worker involvement and those of any additional services alongside Step Change itself in order to gain a full picture of the potential costs and savings associated with the project.

The costs of care

Potential to the merits of the Step Change service is its ability to reduce the adolescent care population and its associated costs. It is an expensive service in itself, providing intensive, licensed interventions but, based on the projected costs of accommodating young people, either in care or custody, for the LAs concerned over a 5 year period, the bid estimated cashable savings of around £10m by diverting approximately 90 young people away from care altogether, and improving outcomes for a further 450.

It is vital for the service to be able to demonstrate improved outcomes alongside cost savings, an outcome which depends heavily on the service reaching young people who are on, or very close to, the edge of care or custody, who would otherwise incur significant accommodation costs for the LA.

As the outcome and implementation studies have revealed, there is some variation in the manner in which the concept of 'edge of care' has been operationalised within the project. Stakeholders acknowledged that some young people not at imminent risk of entering care were indeed referred into the service as a direct result of the drive to increase referrals in order to test the referral pathway processes and ensure therapists had optimal caseloads. Data presented in section 3 also highlights a complex picture in relation to LAC entry and placements. One LA operational lead explained that even though some of their cases ended up becoming LAC, the delay in those placements commencing (which they attributed to Step Change) was a positive outcome in, and of, itself.

The lack of a control group and the short time within which to follow-up young people, meant it was not possible for this study to examine whether Step Change had an impact on care entry, length of stay or placement stability and any associated cost savings to the LAs. This must be a priority for any future roll-out of the project.

4. Limitations of the evaluation and future evaluation

Limitations of the evaluation

There are several important caveats to bear in mind when interpreting the findings reported in section 3 of the report:

- whilst the very small size of the follow-up samples has already been noted, the baseline sample for the outcome evaluation was also relatively small. The number of cases from each LA varied, as would be expected given their size and agreements around allocation of EBP capacity, and the sample for one LA was especially small (n=12), making comparisons across LAs difficult. Improvements in scores on the outcome measures may be explained by regression to mean
- data were patchy, or missing, in relation to key aspects of young people's lives, as well as their service use. The evaluation was dependent on LA systems and, whilst LAs were as co-operative as they could be, their systems did not always hold the data in an easily extractable format. This was exacerbated in some cases by data management being contracted out and/or held across different departments
- the short-term nature of the study limited the scope for understanding the nature and extent of any changes in young people's lives. The trajectories of the young people who received Step Change are likely to be varied and it is possible that additional positive (or negative) impacts from the interventions they received will manifest over a longer time-frame. In that sense, this evaluation provided a preliminary glimpse into short-term outcomes for the young people and families who participated in Step Change
- in the absence of a control group, we were not able to account for the influence of social, political and economic drivers of outcomes, or temporal variables. Therefore we cannot say for sure whether the positive outcomes reported by young people and their families were caused by the Step Change intervention
- qualitative data are only available for families that 'graduated' (i.e. completed the full intervention) and agreed to be interviewed. There is a chance, therefore, of a positive bias within the qualitative data, as the experiences of those who ended the intervention early or unsuccessfully could not be captured

Appropriateness of the evaluative approach

A comparison group-study was neither feasible nor appropriate at this stage in the development of Step Change. The teams delivering the EBPs were newly established

during the course of the current evaluation and the programmes implemented for the first time in these LAs. The introduction of a comparison group would have caused a delay to the research due to the need for consultation with the EBP licensing bodies (a condition of the license agreements). The numbers of families benefiting from Step Change during the first year of implementation were too small to achieve the statistical power needed to detect effects on key outcomes in a comparison group design study.

Despite the success of the project in mobilising quickly and overcoming significant challenges in the set-up of the interventions, there were delays to the project timeline. Given increasing evidence from the field of implementation science, arguably these delays could have been predicted, and perhaps the innovation programme as a whole would have benefited from an evaluation framework that placed less emphasis on outcomes and value for money, and more on the conditions required to develop and implement innovations for young people on the edge of care.

The strength of the evaluation approach adopted for this study can be found in the use of mixed methods, with qualitative data serving to help unpack emerging quantitative findings in relation to change in circumstances and outcomes over time. The use of participatory methods and the formation of a young people's reference group was also a real strength of the study and reflects an increasing movement towards user participation in applied health and social care research.

Future evaluation

The Step Change project may re-emerge in the future, but otherwise, discussion of future evaluation is only relevant to the finite group of families who received an intervention by the time it closed in October 2016. AfC continued to collect monitoring and data for those families who started too late to be included in the evaluation, and this could be interrogated to provide follow up data for the complete sample, albeit for a restricted set of variables. It may also be possible to follow up the families who consented to be interviewed for this study, as the majority of them gave consent for the research team to contact them again in the future.

If Step Change were to re-emerge in the future, we would strongly encourage continued use of the SDQ to monitor outcomes. We recognise that both MST and FFT ask their therapists to administer it for their own evaluative purposes, but would certainly seek to reinforce the importance of this, however awkward it may be sometimes to administer in practice. SDQ has high levels of validity and reliability as a measure of children's mental health (including conduct/behaviour). Though it does have limitations, the SDQ is widely used in social care and in the evaluation of interventions for young people and their families (Bywater and Blower, 2016). SDQ is also used in many cohort and longitudinal studies in the UK – a potential avenue for the compilation of a comparison group in any

future evaluation. Once follow-up data is available for a larger number of young people, there may be an opportunity to use the SDQ added-value algorithm to explore the impact of Step Change over and above spontaneous improvement and other changes in young people's circumstances. The SDQ added-value was specifically developed to predict added value for high-risk groups.

We would also advocate a rigorous study of costs and outcomes associated with Step Change. Trials of MST and FFT are ongoing and will provide further insights on cost effectiveness in the UK. However, Step Change comprises a number of additional key components over and above the EBPs. Following guidance set out by Holmes and McDermid (2012) a future economic evaluation should take full account of the case management and associated processes involved in serving these young people and families, as well as the various components of Step Change, to include not just the EBPs but also the single referral pathway, SCAs , and other costs associated with implementing and running the programme. It is strongly recommended that a bottom-up, or micro-costing, approach is adopted, which involves programme staff completing cost diaries, and young people and their families completing service-use questionnaires such as the SPC or Client Service Receipt Inventory.

A future study should also include a comparison group, ideally closely matched to the Step Change group, if not randomly allocated, in order to generate reliable information about cost-effectiveness. The EBP licensing bodies would need to be consulted before a study of this nature could be implemented. Although the 2 interventions within Step Change are supported by high-quality evidence of their effectiveness in the US and elsewhere, it is acknowledged that further rigorous research is still needed to understand the nature of their impact in a UK context. RCT evaluations of both FFT and MST are currently underway or due to report. These studies will shed further light on their effectiveness (Thurston et al., 2015 and Fonargy et al., 2013).

Depending on the findings of the aforementioned trials, we recommend that any future Step Change project seeks to embed, and ensure adherence to, a monitoring plan that focuses on outcomes for young people, and implementation fidelity. Both EBPs have existing tools and systems that could be utilised for this purpose.

5. Implications and recommendations for policy and practice

Step Change was an ambitious project aiming to improve outcomes for young people and their families by increasing their access to intensive, evidence-based, therapeutic programmes. It aimed to bring about cultural changes within the participating organisations and achieve standardised operational practice and resource efficiencies across 3 LAs. Despite the decision not to continue, it was evident that support for an innovative approach of this nature and its relevance to LAs, particularly in the context of budget cuts, remained strong.

Bearing in mind the limitations and short-term nature of the evaluation, and with reference to the research questions it initially set out to answer, the evaluation offers the following concluding remarks.

Did Step Change appear to make a positive difference to young people and families?

Family Functioning scores had reduced at follow-up, suggesting improved relationships and communication over time. Scores remaining below the cut-off for 'family functioning well' nevertheless demonstrated progress in relation to starting points. Young people's emotional, social and behavioural problems, as scored by the SDQ, also showed some reduction by follow-up, with a smaller proportion of young people identified as having clinically significant difficulties at follow-up than was the case at baseline. Evidence from these outcome measures, therefore, indicated that positive progress was being made. Analysis of the GCI showed improvement over time for 79% of respondents, suggesting that young people were generally more satisfied with their lives by the end of the project.

Whilst clearly indicating a positive direction of travel, the caveats discussed earlier are important (short follow-up time frame and sample size, potential bias of interview sample). That said, it was apparent from interviews with the parents and young people themselves, that most believed that Step Change, and key components within it, had impacted positively on family relationships, alleviating the crisis and some of the difficulties that had brought them to the intervention. Of particular value was the intensity and accessibility of support (24 hours a day for one EBP) and the consistent and supportive relationship with the therapist. Having the time and focus to develop this relationship and develop practical and sustainable solutions was empowering for many parents whose past experience of support had been, in their view, unhelpful. In this sense practitioners suggested that Step Change offered the added value of building bridges between parents and services.

Finally, in terms of the overall aims of Step Change to reduce entry to care, follow-up data from 57 families showed that the majority of young people using Step Change did

not go into care during the evaluation timescale (45, 80%). For 11 (19%) young people who continued, or became, LAC in the follow-up time-frame, their needs were considered to be best met by care:for example, some of these young people were already living with family members and 'entry to care' simply reflected the formalisation of their stable family circumstances.

Which young people and families were more likely to benefit from the approach?

In the absence of a control group or a sufficient sample size at follow-up, it was not possible to explore this question in our overall analysis.

The sample was broadly similar in characteristics and difficulties at baseline, though some were newer referrals to children's services and some had marginally fewer difficulties (which might have served as a proxy for identifying higher or lower need families and potentially those 'closer' to the edge of care). An exploration of any differences between those who appeared to be doing better, however, was not possible due to the lack of completed follow-up data across measures and circumstances.

Was the project implemented as intended at an organisational, cultural and programme level?

In the early stages of the project, several significant changes were made, including the removal of TFCO and the sustainability worker role, as well as the reduction in the number of SCAs employed on the project. Nevertheless, the evidence indicated that the project successfully implemented the majority of its key design elements. The SRP was established across the 3 LAs which, despite adaptations, promoted more standardised practice and shared decision-making in the provision of services to young people on the edge of care. Anecdotal evidence from LA leads, AfC and families suggested that the teams of EBP therapists were performing well and had successfully engaged in their training and supervision processes. The SCAs made good connections in each of the LAs and both supported the identification of eligible participants, and raised awareness of the EBPs. A committed group of operational leads from each organisation came together to build a strong partnership and they reported that the project influenced their thinking around how best to provide support to adolescents experiencing emotional and behavioural difficulties and at risk of family breakdown.

What were the barriers, facilitators and key challenges in the implementation of the approach?

The project generated actionable learning around the obstacles to implementing complex interventions for young people on the edge of care or custody. Barriers included the nature of the bid and bidding process; lack of strategic buy-in, and unequal balance of

power and funding. Facilitators included effective operational staff with a diverse mix of skills and experiences, and good communication between therapists and LA staff.

The decision to close the project was influenced by the following challenges: insufficient time to test and evaluate the impact of the project; the impact of budget cuts and wider austerity measures on LA resources; limited strategic buy-in and insufficient demand. Operational leads suggested matched funding and greater flexibility in procurement regulation as potential enablers of future sustainability that could have made a difference to the decision to close the project.

What were the benefits and drawbacks of sub-regional, local authority collaboration?

Partnership working was one of the innovative elements of Step Change. It was unanimously acknowledged by respondents that the partnership's operational board in particular was a key driving force in successfully implementing the project; individuals from each LA were identified as bringing different skills and experiences that enabled progress on key deliverables.

The drawbacks of the collaboration are largely evident in the barriers to implementation discussed in section 3 and summarised above. Although the LAs had some experience of working together, this had not extended into shared systems or ways of working that could have enabled a more efficient collaboration. For example, data sharing and other agreements needed to be developed from scratch. Geography was consistently identified as a barrier, with travel times between the LAs impacting on the ability of therapists to manage caseloads and day-to-day provision. Arguably, the potential benefits of sub-regional, local authority collaboration are more likely to be realised if there is geographical proximity and pre-existing, shared protocols and compatible information systems.

Did Step Change provide a viable model of alternative edge of care provision?

For reasons already discussed, particularly of time scales and missing data, we were unable to draw any robust conclusions with regards to this question.

Potential for future development

We offer the following comments and suggestions for the future development of Step Change, many of which are ideas generated by Action for Children and the LAs themselves through the process of reflecting on their Step Change experience to date:

- project scale and set-up: given the considerable learning that has already taken place in the process of setting Step Change up for the first time, many of the difficulties experienced in the process are not likely to arise in the same way in the future. For example, service proposals in the future are likely to be more realistically costed, and reflect a better understanding of appropriate staffing ratios
- scoping: more resources could productively be invested in scoping the practicalities of future expansion to additional local authorities, particularly in relation to travel and management information systems. This preparatory work would benefit significantly from the involvement and expert insight of the relevant practitioners
- realistic time-frames: particularly in relation to the set-up phase, time-frames need to take account of the complexity of major tasks such as EBP license acquisition, recruitment and possible practitioner training needs
- better prioritisation of tasks; particularly those related to the recruitment of key staff, such as Step Change Advisors and, if required, EBP supervisors
- project champions: major areas of implementation would benefit from designation to project leads or 'champions'. Key areas include joining up of management systems; data sharing protocols; EBP licensing and site preparation; SRP and referral form preparation; marketing, and practitioner engagement (e.g. Step Change Advisors)
- Step Change manual: the learning gained and preparation of protocols and documentation required for implementation could usefully be synthesised into a manual or handbook to support future replication or expansion
- service integration: a key barrier to this innovation was insufficient integration of intervention staff into or with local authority processes and staff. Whilst the adaptability of the model in this regard needs to be explored, the benefits of greater integration, in principle, were certainly highlighted by key stakeholders
- TFCO: the regret expressed by some stakeholders in relation to the removal of the TFCO programme nominally raises the question of whether it can be re-introduced into any future proposals with other LAs but it is unlikely that the relationship between the potential pool of eligible young people and the costs of providing this particular programme can be made sufficiently attractive

Insights from implementation science have informed the development of a range of frameworks and methods to support the process of implementing complex interventions (e.g. Fixen et al., 2013). Such frameworks offer a potential avenue for systematically operationalising a number of the key learning points from the current study, such as offering methods for mapping demand and site readiness, that may be of use in any

future expansion of the project. The UK Implementation Network offers information on relevant resources.

Although the economic evaluation is modest in scope, it highlights the range of additional services delivered to this cohort of young people, and their associated costs span different sectors and agencies. This finding speaks to the potential for the service (if effective) to produce savings to agencies across the sector including health, education, youth justice and social care. Joint commissioning arrangements involving health and social care within each LA could be one avenue for exploration in any future replication, in order to maximise the chances of sustainable implementation.

Overall, the findings from this study should contribute to the evidence base for developing services to meet the needs of young people on the edge of care or custody and their families.

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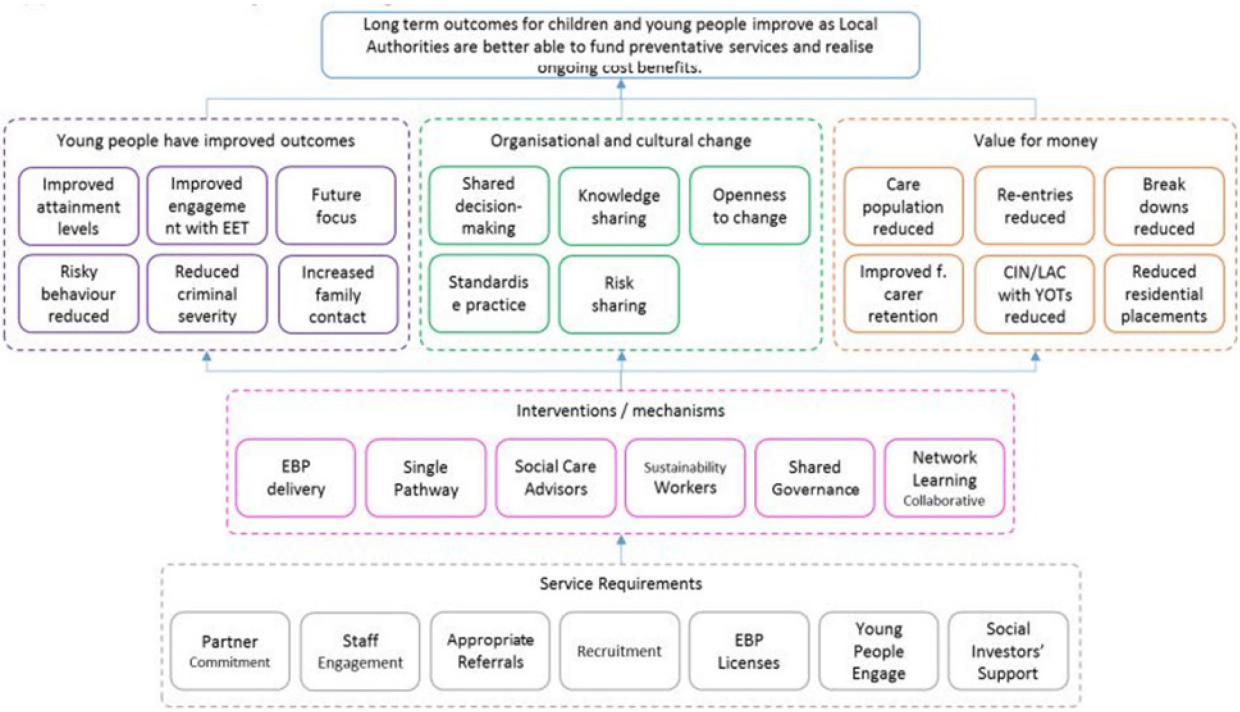
Appendices

Appendix A – Overview of the Step Change project

A1 Theory of Change

Figure 1: Theory of Change for Step Change



A2 Key components of Step Change

Step Change Advisor

Step Change Advisors (employed by AfC) held the following responsibilities: using expert knowledge of the EBPs to raise awareness of them in the LAs; working with LA staff to identify young people who may benefit, and facilitating referrals to the single referral pathway; forming the critical link between the usual system and Step Change to help improve consistency and increase standardised practice.

Single referral pathway

This is a single pathway comprising a shared referral and assessment pathway for all adolescents in the 3 LAs and managed by a panel consisting of 2 Step Change Advisors from each LA and the EBP supervisors. The panel aimed to meet weekly to confirm the allocation of the young people to the most appropriate EBP as part of their care plan.

Suite of EBPs

FFT was developed as a 12-14 session programme delivered over 3 to 5 months. The programme was designed specifically for young people aged 11 to 18 years old with behavioural or emotional problems who have been referred to youth justice, mental health, school or child welfare services. FFT contains 5 major components (engagement, motivation, relational assessment, behaviour change and generalisation). Collectively these components work together in an attempt to improve inter-family relationships, family communication and supportiveness whilst decreasing intense negativity and dysfunctional patterns of behaviour including violence, offending and school non-attendance.

MST was designed as an intensive family and community intervention for young people aged 11-17 years of age at risk of care or custody due to offending or severe behavioural problems. Therapists support the family for several hours per week over the course of 3 to 5 months. Unlike FFT, MST does not require full engagement with young people, as it works with representatives of all the systems in the child's life. The main goal of MST is to decrease rates of antisocial behaviour and other clinical problems; improve family relations and school performance, and reduce societal costs by reducing the use of out-of-home placements.

A3 Eligibility for the EBPs

MST

The young person should be between the ages of 11 and 17 and at risk of going into care due to their antisocial behaviour and/or their involvement in juvenile offending. This may include the young person showing physical or verbal aggression at home, at school or in the community, and/or substance misuse problems.

Inclusion criteria:

- young person at risk of care or custody
- young person is living at home
- referral behaviour of the young person occurs in at least 2 domains (e.g. at home, at school, in the community)

Exclusion criteria:

- young person lives independently, or a primary caregiver cannot be identified despite all efforts
- referred primarily because of serious psychiatric problems, including suicide risk and psychotic behaviours

- referred due to juvenile sex offending
- young person has pervasive developmental delays

FFT

Families are carefully screened for eligibility during the pre-treatment assessment. Young people must be aged 10 years or older and not demonstrate evidence of psychosis or experience severe learning difficulties. FFT does work with young people who are displaying emotional and/or behavioural difficulties. The young person should also be living at home with their primary caregiver(s). The intervention is able to support young people who have a history of offending (including serious crimes) but is not designed to support young people who have a history of sexual offending.

Inclusion criteria:

- the young person displays emotional and/or behavioural difficulties in at least one domain of the young person's life, e.g. referral behaviour can include violence and conflict in the home linked to a breakdown in relationships within the home
- the young person is living at home. Step Change FFT therapists will work with young people living away from home where there is a plan to return home within 4 weeks. FFT will carry out reunification work with the young person and parents in preparation to return home and then continue to work with the family once the young person is home

Exclusion criteria:

- history of sexual offending
- evidence of psychosis
- severe learning difficulties

Appendix B – Methodology

B1 Young people's reference group methodology

A young people's reference group for this study was established. In order to protect the anonymity of the participants within the 3 Step Change Local Authorities, it was drawn from a previously established group from a neighbouring LA from within the West London Alliance. The group of 6 young people, each with experience of the care system and who were active within their local children in care council, agreed to act as the reference group. They met 5 times during the course of the research: 4 times within their local area and once at a residential research workshop with other young people held at the University of York in February 2016. Their contribution included helping to develop the

young people's invitation to interview and information leaflet, and advising on the development of the interview schedule for young people. The final session with the reference group involved the young people coming to the University of York for a 2 day residential workshop with other young people from research reference groups for 2 other Innovation Programme projects. The focus was on young people's participation in research and disseminating findings.

B2 Outcome evaluation methodology

To supplement routinely collected data, 2 standardised measures of Step Change outcomes were administered, on behalf of the evaluation, by therapists at the start of each intervention and repeated at the penultimate therapy session. The parent and youth self-report versions of the SDQ (Goodman, 1997) were utilised to measure young people's emotional and behavioural difficulties and the SCORE-15 (Stratton et al., 2014, parent and youth self-report) was administered to capture family functioning. These measures were selected in collaboration with the project and following consultation with the EBP licensing bodies. Available evidence suggests they are reliable and valid for our study population and that they measure key constructs related to the intended outcomes of FFT and MST. Minimising the burden on families and their therapists was also a significant consideration: an advantage of SDQ and SCORE-15 is that they are both already routinely administered by FFT therapists. Similarly MST therapists already administer SDQ, and, for the purposes of this study, added the SCORE-15.

The SDQ is a brief behavioural screening questionnaire. It comprises 25 items on psychological attributes, a mixture of positive and negative, which comprises 5 subscales of emotion, hyperactivity, peer problem, conduct problems, and prosocial. With the exception of the pro-social behaviour subscale, higher scores on all other subscales indicate greater difficulties. Thresholds can be applied to the scores in order to understand the severity of difficulties and extent to which they are within the normal range for typically developing young people or at a severity that would indicate the young people may have a clinically diagnosable condition such as conduct disorder.

SCORE-15 was designed to enable family members to report on aspects of their interactions with a focus on strengths, difficulties and communication. The tool has 15 Likert scale items, and 6 separate indicators, 3 of them qualitative. Average scores were calculated for each subscale (strengths and adaptability, overwhelmed by difficulties, disrupted communications) and overall family functioning. The lower the score - the higher the functioning. SCORE-15 has been adopted as part of the CORC guidance (CAMHS Outcomes Research Consortium http://www.corc.uk.net). This tool was already being routinely administered by FFT therapists as part of the intervention's internal monitoring processes.

In addition to the 2 outcome measures, data on young people's satisfaction with their life were gathered at baseline and follow-up using the GCI. The GCI was developed following detailed qualitative and quantitative research with children and young people (The Children's Society, 2015). It should be noted that this measure has not been validated for use with small samples or specifically to test effectiveness of interventions and services. The tool comprises 12 items measuring subjective wellbeing in aspects of children's lives which they say, and analysis shows, are important to them. A single-item question asks children to rate their happiness and satisfaction in 10 domains on a 0 (very unhappy) – 10 (very happy) scale; one multi-item question asks children how far they agree with statements relating to their overall subjective wellbeing, on a 5-point scale ranging from 'strongly agree' to 'strongly disagree'.

Further information on family circumstances and experiences of Step Change, was gathered via qualitative interviews with 15 families who had completed the intervention. Therapists, on behalf of the evaluation team, explained the evaluation and opportunity to participate in research interviews to young people and families who were nearing completion of their intervention. Parents who were interested in the interviews gave initial consent for project staff to pass their contact details to the evaluation team. Upon receipt of the contact details, the evaluation team attempted to contact the family and, if successful, provided further information. If the families verbally agreed to be interviewed at this stage, an appointment was made for a researcher to visit the family in their home at a time and date convenient for both the parent and young person. The interviews lasted approximately 45 minutes with children, and one hour with parents. All participants (parents and young people) were paid £15 each in high street shopping vouchers for sparing their time.

We set out to interview parents, the index young person (that is, the young person referred to Step Change) and, in some cases, their sibling. However, this was not always possible as some young people did not wish to be interviewed. In total 28 interviews were carried out with 15 families that agreed to have their contact details shared with the evaluation team. From these families, 15 parents were interviewed together with 12 index young people and 2 siblings.

B3 Implementation evaluation methodology

The first wave of electronic surveys (in October 2015) explored general perspectives on the key strengths, weaknesses, barriers and facilitators associated with Step Change, and the extent stakeholders felt the service may meet the needs of the young people it served. Survey questions were informed by the Step Change logic model and linked to key factors known to influence the process of implementing complex interventions (Damschroder et al., 2009). A purposive sampling method was used to ensure that a broad range of stakeholders were able to share their views on the project. A second

survey was administered 9 months later (July 2016) to capture information on the delivery and perceived impact of the project from those delivering it (that is, therapists that were not in post at the time of the first wave of surveys) and to explore experiences of frontline social workers referring families to the project.

Baseline telephone interviews were carried out between November and December 2015 with 16 key stakeholders, which included representatives from the following groups: the Step Change Strategic Board, Step Change Operational Board, Evidence Based Programmes (MST and FFT), External Adviser Organisations (New York Foundling and Spring Consortium). The interviews were designed to gather in-depth information and stakeholder perspectives on the set-up and initial implementation of the project. A second wave of interviews was conducted in the final month of the project to capture views from operational leads representing each of the Local Authorities and AfC on the sustainability of Step Change. The interview schedules were semi-structured and, in addition to a core group of questions common to all schedules, were tailored, where relevant, to include questions relating specifically to the role of the participant concerned. The interviews were recorded and transcribed, and a thematic analysis (Braun and Clarke 2006; Damschroder et al., 2009) was carried out.

In order to explore how the Step Change panels were being implemented and to further explore how decisions about service eligibility were being operationalised, direct observation was conducted by one researcher who attended a total of 2 panel meetings. The researcher made unstructured notes of their observations.

B4 Economic evaluation methodology

Service use data was requested from the Local Authorities on all young people in the sample as part of the data extraction processes described in the outcome evaluation methodology. There were considerable gaps in the returned data.

The SPC was administered to explore resource use of families involved with Step Change. The SPC focused on contact time with Step Change staff and any other additional services accessed by families during the 3 months prior to completing the checklist. The SPC was administered to families who consented during an interview with a member of the evaluation team. They represent a sub-sample of families who had reached the end of the intervention and were willing to share their experiences.

Appendix C – Tables

Table 6: Outcome evaluation - data collection and sample sizes

Timepoint	Source of data	LA 1	LA2	LA3	Total
Baseline	Step Change project: referral form for all referrals	49	39	42	130
Baseline	Step Change project: referral form for eligible sample	27	17	23	67
Baseline	LA: Case management data (some data items missing)	27	17	23	67a
Baseline	Evaluation: SDQ (YP)	18	12	12	42
Baseline	Evaluation: SDQ (Parent)	20	15	16	51
Baseline	Evaluation: Score 15 (YP)	18	11	10	39
Baseline	Evaluation: Score15 (Parent)	22	15	17	54
Baseline	Evaluation: GCI (YP)	18	13	14	45
Follow-up	Step Change Project: AfC Case tracker	24	12	21	57
Follow-up	LA: Case management system data	24	12	21	57b
Follow-up	Evaluation: SDQ (YP)	7	2	2	11
Follow-up	Evaluation: SDQ (Parent)	9	4	3	16
Follow-up	Evaluation: Score 15 (YP)	8	6	2	16
Follow-up	Evaluation: Score15 (Parent)	9	5	4	18
Follow-up	Evaluation: GCI (YP)	8	5	3	16
Follow-up	Evaluation: interviews with parents/carers	6	5	4	15
Follow-up	Evaluation: interviews with young people (incl. sibling)	5	5	3	13
Follow-up	Evaluation: survey of Step Change therapists/supervisor	N/A	N/A	N/A	7
Follow-up	Evaluation: survey of referring Social/YOS workers	1	3	10	14

a: Some baseline data items were returned for all 67 cases: however, there was considerable missing data with some items being returned for as few as 39 cases (see characteristics table for N for items).
b: As above - complete follow-up data was not available for all 57 cases.

Table 7: Implementation evaluation - data collection and sample sizes

Timepoint	Source of data	AfC	LA1	LA2	LA3	Total
Baseline	Electronic Survey with stakeholders	11	6	5	6	28
Baseline	Telephone interviews with AfC. LA strategic and operational leads	4	2	2	2	10
Baseline	Telephone interviews with EBP supervisors and therapists	4	N/A	N/A	N/A	4
Baseline	Telephone interview with external advisors New York Foundlings	N/A	N/A	N/A	N/A	1

Timepoint	Source of data	AfC	LA1	LA2	LA3	Total
Baseline	Telephone interview with external advisors: Spring Consortium	N/A	N/A	N/A	N/A	1
Follow-up	Telephone interview with step change lead from each partner	N/A	N/A	N/A	N/A	4
Follow-up	Electronic survey of Step Change therapists/supervisor	7	N/A	N/A	N/A	7
Follow-up	Electronic evaluation: survey of referring Social/YOS workers	N/A	1	3	10	14

Table 8: Economic evaluation - data collection and sample sizes

Timepoint	Source of data	AfC	LA 1	LA2	LA3	Total
Baseline	LA case management data	N/A	27	17	23	67a
Follow-up	LA case management data	N/A	24	12	21	57b
Follow-up	Self-completed Service Provision Checklist (parent)	N/A	6	5	4	15

a: Some baseline data items were returned for all 67 cases; however, there was considerable missing data with some items being returned for 0 cases.

b: Complete follow-up data was not available for all 57 cases.

Table 9: Case validity by LA

Referrals	LA1	LA2	LA3	Total
Not an eligible SC referral	5	6	5	16 (12%)
Not eligible for EBPs	1	2	1	4 (3%)
Eligible for SC and took up EBP	27	17	23	67 (52%)
Family eligible but disengaged before start of EBP	4	3	5	12 (9%)
Eligible but no service capacity	1	1	1	3 (2%)
Valid but not allocated within evaluation timescale	11	10	7	28 (22%)
Total referrals	49	39	42	130

Table 10: Allocation to EBP by LA

LA	SC sample	FFT	MST
LA1	27	19	8
LA 2	17	12	5
LA3	23	11	12
Total	67 (100%)	42 (63%)	25 (37%)

Table 11: Characteristics and circumstances of young people and their caregivers at pre-baseline/baseline

	LA1	LA2	LA3	TOTAL SC SAMPLE
Total number of cases	**27 (40%)**	**17 (26%)**	**23 (34%)**	**67**
Referrals and allocations				
Crisis panel case	0 (0%)	0 (0%)	2 (100%)	2 (100%)
Allocated to FFT	19 (70%)	12 (71%)	11 (48%)	42 (63%)
Allocated to MST	8 (39%)	5 (29%)	12 (52%)	25 (37%)
Demographics				
Male	19 (70%)	9 (53%)	14 (61%)	42 (63%)
Age:				
10 years	1 (4%)	0 (0%)	0 (0%)	1 (1%)
11-13 years	7 (28%)	4 (23%)	3 (13%)	14 (21%)
14-15 years	16 (59%)	10 (59%)	14 (61%)	40 (60%)
16-17 years	3 (11%)	3 (18%)	6 (26%)	12 (18%)
Ethnicity:				
White (UK)	15 (58%)	6 (38%)	12 (52%)	33 (51%)
White (Other)	3 (12%)	1(6%)	1(4%)	5 (8%)
Asian (including British Asian)	0 (0%)	2 (13%)	3(13%)	5 (8%)
Black/African/Caribbean background	3 (12%)	4 (25%)	3 (13%)	10 (15%)
Any Mixed/Multiple ethnic background	4 (15%)	1 (6%)	3 (13%)	8 (12%)
Other ethnic group not listed above	1 (4%)	2 (13%)	1 (4%)	4 (6%)
Learning disability	3 (12%)	3 (18%)	2 (9%)	8 (13%)
Physical disability	1 (4%)	0 (0%)	2 (9%)	3 (6%)
Mental health difficulties	3 (12%)	1 (6%)	1 (4%)	5 (8%)
Background and history				
Time from 1st referral to Children's Social Care to baseline:				
< 1 year	6 (22%)	5 (29%)	5 (22%)	16 (24%)
1-3 years	7 (26%)	10 (59%)	8 (35%)	25 (37%)
4 – 8 years	6 (22%)	1 (6%)	5 (22%)	12 (18%)
9 or more years	8 (30%)	1 (6%)	5 (22%)	14 (21%)
Age of young person at 1st referral (n=66)				
0	3 (11%)	0 (0%)	1 (4.5%)	4 (6%)
1-4	5 (19%)	0 (0%)	2 (9%)	7 (11%)
5-9	7 (26%)	2 (12%)	4 (18%)	13 (20%)
10-15	12 (44%)	14 (82%)	15 (68%)	41 (62%)
16 and over	0 (0%)	1 (6%)	0 (0%)	1 (1%)
Primary need reported at first referral (n=63):				

Abuse or neglect	4 (15%)	5 (36%)	16 (72%)	25 (40%)
Family dysfunction	13 (48%)	6 (43%)	3 (14%)	22 (35%)
Socially unacceptable behaviour	5 (19%)	3 (21%)	0 (0%)	8 (13%)
Family in acute stress	4 (15%)	0 (0%)	3 (14%)	7 (11%)
Child's disability	1 (4%)	0 (0%)	0 (0%)	1 (2%)
Primary need reported at most *recent* referral (n=40):				
Abuse or neglect	5 (39%)	8 (47%)	8 (80%)	21 (53%)
Family in acute stress	3 (23%)	3 (18%)	1 (10%)	7 (17%)
Socially unacceptable behaviour	2 (15%)	4 (23%)	0 (0%)	6 (15%)
Family dysfunction	3 (23%)	2 (12%)	1 (10%)	6 (15%)
Subject to CIN plan within the last 3 years	24 (89%)	10 (59%)	15 (65%)	49 (73%)
Subject to CP plan within the last 3 years	12 (44%)	4 (24%)	2 (9%)	18 (27%)
Subject to Care proceedings within the last 3 years	8 (30%)	1 (6%)	2 (9%)	11 (16%)
Previously looked after at any time	9 (33%)	4 (24%)	7 (30%)	20 (30%)
At least one LAC episode in previous 3 years	9 (33%)	4 (24%)	6 (26%)	19 (29%)
Still LAC at baseline	2 (22%)	0 (0%)	2 (33%)	4 (6%)
Family composition/Where YP was living at referral (n=56)				
Single parent household	12 (75%)	10 (59%)	18 (78%)	40 (71%)
2 birth parent household	2 (13%)	6 (35%)	4 (18%)	12 (21%)
Other relatives/family household	1 (6%)	0 (0%)	1 (4%)	2 (4%)
Blended/step family	0 (0%)	1 (6%)	0 (0%)	1 (2%)
50-50 with separated parents	1 (6%)	0 (0%)	0 (0%)	1 (2%)
Risk factors as listed on SC Referral Form				
At risk of entry to care due to antisocial, challenging or offending behaviour	25 (93%)	6 (35%)	19 (82%)	50 (75%)
High affiliation with anti-social peers	16 (59%)	5 (29%)	11 (48%)	32 (48%)
At least one period of short term care in the last 12 months	8 (30%)	2 (12%)	6 (26%)	16 (24%)
Siblings subject to care placements (where YP known to have at least one sibling)	4 (29%, n=14)	1 (8%, n=12)	5 (24%, n=21)	10 (21%, n=47)
Multiple referrals to agencies	16 (59%	9 (53%)	15 (65%)	40 (60%)
Aggressive behaviour (violence, fighting, property destruction)	17 (63%)	11 (65%)	19 (83%)	47 (70%)
Violence within the home, directed at parents or siblings	19 (70%)	14 (82%)	20 (87%)	53 (79%)
Serious disrespect/disobedience (where	13 (93%,	4 (67%,	9 (82%,	26 (84%,

known)	n=14)	n=6)	n=11)	n=31)
Permanent exclusion or dropping out of education	9 (33%)	3 (18%)	16 (70%)	28 (42%)
Multiple fixed period exclusions for behaviour	15 (56%)	8 (37%)	9 (49%)	32 (48%)
Unauthorised absence from school	14 (52%)	8 (47%)	18 (78%)	40 (60%)
Baseline risk: criminal behaviour	9 (33.3%)	4 (23.5%)	10 (43.5%)	23 (34%)
Substance abuse impacting on behaviour or family	12 (44%)	0 (0%)	10 (44%)	22 (33%)
Running away	14 (52%)	3 (18%)	7 (30%)	24 (36%)
Additional risk factors from LA Data				
Self-harm (n=40)	---	8 (47.1%)	6 (26.1%)	14 (35 %)
Baseline risk: child sexual exploitation (CSE) (n=40)	---	6 (35.3%)	6 (26.1%)	12 (30 %)
Involvement in offending				
Number of offences recorded for YP up to baseline (n= 46):				
0	3 (50%)	14 (82%)	12 (52%)	29 (63 %)
1	0 (0%)	2 (12%)	6 (26%)	8 (17%)
2-4	2 (34%)	0 (0%)	5 (22%)	7 (16%)
5+	1 (16%)	1 (6%)	0 (0%)	2 (4%)
Education				
Main activity (n=39):				
Secondary school	---	13 (77%)	9 (40%)	22 (56%)
Pupil referral unit	---	2 (12%)	6 (27%)	8 (20%)
Special unit in mainstream school	---	0 (0%)	2 (9%)	2 (5%)
Further education	---	1 (6%)	1 (5%)	2 (5%)
Home tuition	---	1 (6%)	0 (0%)	1 (3%)
Missing from school/not attending	---	0 (0%)	2 (9%)	2 (5%)
NEET	---	0 (0%)	1 (5%)	1 (3%)
Other	---	0 (0%)	1 (5%)	1 (3%)

Notes:
All percentages rounded up to nearest whole number.
The data in this table are sourced from referral forms and LA data for 67 cases. Percentages are based on 67 cases unless otherwise stated (e.g. n is given if data are missing for some variables)
Where missing data accounts for 50% or more of the total cases or of the cases within one LA, figures are not reported.

Table 12: Characteristics of the Step Change sample at follow-up

Characteristics and circumstances	LA 1	LA 2	LA3	Total
Valid cases at follow-up	24	12	21	57
Number of days between referral and entry to Step Change	Mean 23 Mode 14 Range 4-62	Mean 23 Mode13 Range 4-64	Mean 24 Mode 9 Range 6-126	Mean 24 Mode 9 Range 4-126
Number of weeks in Step Change	Mean 18 Mode 14 Range 7-26	Mean 19 Mode 20 Range 7-28	Mean 16 Mode15 Range 10-22	Mean 17 Mode15 Range 7-28
Case Closed at follow-up	15 (63%)	7 (58%)	14 (67%)	36 (63%)
Single parent household	9 (38%)	7 (58%)	7 (33%)	23 (40%)
2 birth parents	8 (33%)	3 (25%)	1 (5%)	12 (21%)
Other family member	1 (4%)	1 (8%)	/	2 (4%)
Blended/step family	/	1 (8%)	/	1 (2%)
Foster carer / kinship carer	2 (8%)	/	/	2 (4%)
Residential carer	4 (17%)	/	1 (5%)	5 (9%)
Semi-independent placement	1 (4%)	/	/	1 (2%)
Other missing	3 (13%)	5 (42%)	13 (62%)	21 (37%)
Secondary school	missing	4 (33%)	9 (43%)	13 (23%)
Pupil referral unit	missing	2 (17%)	8 (38%)	10 (18%)
Special unit in mainstream school	missing	1 (8%)	0	1 (2%)
Further education	missing	3 (25%)	1 (5%)	4 (7%)
School for children with special needs	missing	1 (8%)	1 (5%)	2 (4%)
NEET	missing	1 (8%)	/	1 (2%)
Number who did not enter care by follow-up (n=56)	19 (79%)	10 (83%)	16 (76%)	45 (79%)
Number entered care between entry to Step Change and follow-up	5 (21%)	2 (17%)	4 (19%)	11 (19%)
Weeks between entry to Step Change and entry to care over follow-up	Mean 13 Mode10 Range 7-27	Mean 7 Mode 2 Range 2-12	Mean 9 Mode12 Range 0-18	Mean 10 Mode 0 Range 0-27
Number of young people who committed offence over follow-up	missing	2 (17%)	5 (24%)	7 (12%)
Number of offences committed over follow-up	missing	Range 0-2	Range 0-3	Range 0-3

Notes:
'/' is used to indicate partial missing data for data items.

Table 13: GCI Domains of subjective wellbeing

Life domain	10-17 year olds in the UK Mean	Step Change Mean	Step Change Unhappy
Family (n=44)	8.4	5.8	32%
Choice (n=43)	7.0	5.2	33%
Money and things (n=43)	7.2	6.4	23%
Health (n=45)	8.1	6.2	22%
Friends (n=45)	8.0	7.2	16%
Appearance (n=44)	7.0	6.4	25%
Future (n=45)	6.6	5.4	29%
Home (n=45)	8.0	6.2	29%
School or college (n=40)	7.1	5.1	38%
Time use (n=44)	7.4	5.9	25%

Table 14: SCORE-15 clinical cut-offs reported by parents (n=18)

Timepoint	Function-ing well (parent)	Significant problems (parent)	Very significant problems (parent)	Function-ing well (parent)	Significant problems (parent)	Very significant problems (parent)
Baseline	6	6	6	5	10	0
Follow-up	9	7	2	11	4	0

Table 15: SDQ bandings at baseline and follow-up as reported by primary caregivers

Baseline (n=51)	Close to Average	Slightly raised	High	Very High
Emotional difficulties	15 (29%)	6 (12%)	11 (22%)	19 (37%)
Conduct problems	7 (14%)	4 (8%)	12 (24%)	28 (55%)
Hyperactivity	14 (28%)	15 (29%)	7 (14%)	15 (29%)
Peer Problems	17 (33%)	13 (26%)	10 (20%)	11 (22%)
Prosocial Behaviour*	15 (29%)	5 (10%)	5 (10%)	26 (51%)
Total Difficulties	9 (18%)	6 (12%)	7 (14%)	29 (57%)
Follow-up (n=16)	**Close to Average**	**Slightly raised**	**High**	**Very High**
Emotional difficulties	7 (44%)	5 (31%)	2 (13%)	2 (13%)
Conduct problems	7 (64%)	0 (0%)	2 (18%)	2 (18%)
Hyperactivity	8 (50%)	3 (19%)	3 (19%)	2 (13%)
Peer Problems	6 (38%)	5 (31%)	3 (19%)	2 (13%)
Prosocial Behaviour*	7 (44%)	3 (19%)	1 (6%)	5 (31%)
Total Difficulties	8 (50%)	1 (6%)	1 (6%)	6 (38%)

*Prosocial behaviour scores are reversed, that is, slightly lowered, low or very low

Table 16: SDQ bandings at baseline and follow-up 1 as reported by young people

Baseline (n=42)	**Close to Average**	**Slightly raised**	**High**	**Very High**
Emotional difficulties	20 (48%)	7 (17%)	4 (7%)	11 (19%)
Conduct problems	14 (33%)	2 (5%)	10 (24%)	16 (38%)
Hyperactivity	14 (33%)	6 (14%)	6 (14%)	16 (38%)
Peer Problems	17 (41%)	8 (19%)	5 (12%)	12 (29%)
Prosocial Behaviour*	9 (21%)	7 (17%)	8 (19%)	18 (43%)
Total Difficulties	10 (24%)	6 (14%)	3 (7%)	23 (55%)
Follow-up 1 (n=11)	**Close to Average**	**Slightly raised**	**High**	**Very High**
Emotional difficulties	6 (55%)	2 (18%)	1 (9%)	2 (18%)
Conduct problems	5 (46%)	3 (27%)	1 (9%)	2 (18%)
Hyperactivity	6 (55%)	3 (27%)	2 (18%)	0 (0%)
Peer Problems	2 (18%)	3 (27%)	2 (18%)	4 (36%)
Prosocial Behaviour*	4 (36%)	3 (27%)	3 (27%)	1 (9%)
Total Difficulties	4 (36%)	0 (0%)	3 (27%)	4 (36%)

*Prosocial behaviour scores are reversed, that is, slightly lowered, low or very low

Table 17: Wave 2 implementation survey responses

Satisfaction with…	**Satisfied**	**Dis-satisfied**	**Neither Satisfied nor Dis-satisfied**
The process for referring families to SC (n=15)	10 (67%)	4 (27%)	1 (7%)
The process for assessing families' eligibility for a SC intervention (n=17)	6 (35%)	3 (18%)	8 (47%)
The process for allocating families to a SC intervention (n=14)	6 (42%)	4 (29%)	4 (29%)
The process for communicating family progress between SC and LA staff (n=15)	11 (74%)	2 (13%)	2 (13%)
The process for families exiting the SC intervention (n=13)	8 (62%)	1 (8%)	4 (30%)
Working with the LAs (therapists only, n=7)	2 (29%)	1 (14%)	4 (57%)
Working with the therapists (referring social workers only, n=8)	4 (50%)	2 (25%)	2 (25%)
Working with AfC (therapists only, n=7)	3 (43%)	0 (0%)	4(57%)
Capacity of SC to work with the number of families that need the service (referring social workers only, n=8)	4 (50%)	2 (25%)	2 (25%)
Training (therapists only, n=7)	4 (57%)	0 (0%)	3 (43%)
Supervision (therapists only, n=7)	3 (43%)	1 (14%)	3 (43%)
SC caseloads (therapists only, n=7)	4 (57%)	0 (0%)	3 (43%)

Table 18: Unit costs of FFT and MST

EBP	£	Unit	Source
FFT	£51	per hour	Unit costs assumed to be the same as for MST due to level of skills, experience and qualifications required of therapists.
MST	£51	per hour	Curtis and Burns (2015) Unit costs of health and social care, schema 6.7

Table 19: FFT and MST resource use

Therapist	Average contact time: Mean hours (SD)
FFT therapist (n=8)	14.5 (7.0)
MST therapist (n=7)	47.7 (38.8)

Table 20: Cost of contact with FFT and MST therapists in 3 month period

Therapist	Average cost of contact with Step Change therapist: £ Mean (SD)
FFT therapist (n=8)	827 (357)
MST therapist (n=7)	2433 (1978.80)
Total	3260 (2335.80)

Table 21: Unit costs of additional services

Service use	£	Unit	Source
Children's Social Worker	£79	Per hour of client-related work	Curtis and Burns (2015) schema 11.3 – client-related work
Family Support Worker	£51	Per hour	Curtis and Burns (2015) schema 11.8 – client related work
GP (or community nurse)	£44	Per patient contact lasting 11.7 minutes	Curtis and Burns (2015) schema 10.8b – GP with qualification costs
Hospital doctor or nurse	£116	Per A and E attendance	Accident and Emergency Services, NHS Reference costs 2012/13 – inflated for financial year 2014/2015
Child and Adolescent Mental Health Service	£113	Per hour	Curtis and Burns (2015) schema 12.7 – multidisciplinary CAMHS face-to-face contact
Other specialist mental health Worker	£81.50	Per hour	Family Savings Calculator: Department for Education, 2009 – psychologist, inflated for financial year 2014/2015
Substance use	£29.64	Per hour	Family Savings Calculator:

Service use	£	Unit	Source
worker			Department for Education, 2009 - inflated for financial year 2014/2015
Education support staff	£22.99	Per hour	Holmes et al (2012), inflated for financial year 2014/15 – educational welfare officer
Housing or homelessness workers	£38.28	Per hour	Family Savings Calculator: Department for Education, 2009 - inflated for financial year 2014/15
Youth offending team	£33.67	Per hour	Holmes et al (2012) inflated for financial year 2014/15, YOT worker

Table 22: Additional services accessed in past 3 months

Contact with services	Number of families with at least 1 contact (% of sub-sample)	Average contact for those who had at least 1 contact: Mean hours (SD)	Average contact time for all 15 families: Mean hours (SD)
Children's Social Worker	13 (87%)	4.1 (3.1)	3.6 (3.2)
Family Support Worker/Family Intervention worker	4 (27%)	7 (5.8)	1.9 (4.2)
Adult social worker	0 (0%)	0 (0)	0 (0)
GP or community nurse	5 (33%)	1.9 (1.5)	0.6 (1.2)
Hospital doctor or nurse	6 (40%)	2.6 (1.3)	1.0 (1.5)
Child and Adolescent Mental Health Service (CAMHS)	6 (40%)	1.5 (0.8)	0.6 (0.9)
Other specialist mental health Worker (psychologist, psychiatrist, or counsellor)	2 (13%)	3 (0)	0.4 (1)
Substance use worker (drugs, alcohol)	3 (20%)	5.3 (5.9)	1.1 (3.1)
Education staff (education welfare office, educational psychologist)	5 (33%)	5.8 (5.7)	1.9 (4.2)
Housing or homelessness workers	1 (6%)	3 (0)	0.2 (0.7)
Youth offending team	6 (40%)	13 (5.9)	5.2 (7.5)
Probation	0 (0%)	0 (0)	0 (0)
Other	1 (7%)	12 (0)	0.8 (3.1)

Table 23: The costs of additional services accessed in past 3 months

Contact with services	Average cost for those who had at least 1 contact: £ mean (SD)	Average cost for whole sample: £ mean (SD)
Children's Social Worker	323.90 (244.90)	284.40 (252.80)
Family Support Worker/Family Intervention worker	357.00 (295.80)	96.90 (214.20)
Adult social worker	0	0
GP or community nurse	220.40 (174.00)	69.60 (139.20)
Hospital doctor or nurse	293.80 (146.90)	113.00 (169.50)
Child and Adolescent Mental Health Service	122.25 (65.20)	48.90 (73.35)
Other specialist mental health Worker (e.g. psychologist)	88.92 (0)	11.86 (29.64)
Substance use worker (drugs, alcohol)	121.85 (135.64)	25.29 (71.27)
Education staff (e.g. education welfare office)	222.02 (218.20)	72.73 (160.78)
Housing or homelessness workers	101.01 (0)	6.73 (23.57)
Youth offending team	1027.00 (466.10)	410.80 (592.50)
Probation	0	0
Other	528 (0)	35.20 (136.40)
Total average costs of additional services	3406.15 (1746.74)	1175.41 (1863.20)

Table 24: Frequency of social worker involvement

LA	Social worker involved at baseline	Mean average number of social worker contacts with family at baseline (SD)	Social worker involved at follow-up	Mean average number of social worker contacts with family at follow-up (SD)
LA2 (n=10)	9 (90%)	6.7 (4.7)	9 (90%)	6.8 (5.5)
LA3 (n=21)	19 (91%)	16.5 (12.8)	20 (95%)	21.9 (11.2)

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